Filing at a Glance

Company:	Delta Dental of Arkansas
Product Name:	WS dental certs
State:	Arkansas
TOI:	H10G Group Health - Dental
Sub-TOI:	H10G.000 Health - Dental
Filing Type:	Form
Date Submitted:	08/27/2012
SERFF Tr Num:	DDAR-128660188
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	WS CERTS 12A
Implementation Date Requested:	
Author(s):	Sara Farris
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	09/10/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* ***Filing Company:*** *Delta Dental of Arkansas*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *WS dental certs*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type:
Filing Status Changed: 09/10/2012
State Status Changed: 09/10/2012
Created By: Sara Farris
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type:
Overall Rate Impact:

Deemer Date:
Submitted By: Sara Farris

Filing Description:

A large group has made changes to its certificates for active employees and retirees.

Company and Contact

Filing Contact Information

Sara Farris,
1513 Country Club
Sherwood, AR 72120

sfarris@ddpar.com
501-992-1662 [Phone]
501-992-1663 [FAX]

Filing Company Information

Delta Dental of Arkansas
1513 Country Club Rd.
Sherwood, AR 72120
(501) 992-1662 ext. [Phone]

CoCode: 47155
Group Code:
Group Name:
FEIN Number: 71-0561140

State of Domicile: Arkansas
Company Type:
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $0.00
Retaliatory? No
Fee Explanation:
Per Company: No

Company	Amount	Date Processed	Transaction #
Delta Dental of Arkansas	$50.00	08/27/2012	62038703
Delta Dental of Arkansas	$50.00	09/07/2012	62502102

SERFF Tracking #:	*DDAR-128660188*	***State Tracking #:***		***Company Tracking #:***	*WS CERTS 12A*

State:	*Arkansas*	***Filing Company:***	*Delta Dental of Arkansas*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*WS dental certs*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/10/2012	09/10/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	09/07/2012	09/07/2012

Response Letters

Responded By	Created On	Date Submitted
Sara Farris	09/07/2012	09/07/2012

SERFF Tracking #:	*DDAR-128660188*	***State Tracking #:***		***Company Tracking #:***	*WS CERTS 12A*

State:	*Arkansas*	***Filing Company:***	*Delta Dental of Arkansas*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*WS dental certs*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 09/10/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form	DDPAR-WS_ 9618_9619_9620_ACTIVE CERT-12A	Approved-Closed	Yes
Form	DDPAR-WS RETIREE CERT-12A	Approved-Closed	Yes

State: Arkansas **Filing Company:** Delta Dental of Arkansas
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: WS dental certs
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/07/2012
Submitted Date	09/07/2012
Respond By Date	

Dear Sara Farris,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- DDPAR-WS_ 9618_9619_9620_ACTIVE CERT-12A, (Form)
- DDPAR-WS RETIREE CERT-12A, (Form)
Comments:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $100.00. Please submit an additional $50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

State: Arkansas **Filing Company:** Delta Dental of Arkansas
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: WS dental certs
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/07/2012
Submitted Date	09/07/2012

Dear Rosalind Minor,

Introduction:

Response 1

Comments:

I apologize for the oversight. The additional fee has been submitted. Thank you.

Related Objection 1

Applies To:

- *DDPAR-WS_ 9618_9619_9620_ACTIVE CERT-12A, (Form)*
- *DDPAR-WS RETIREE CERT-12A, (Form)*

Comments:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $100.00. Please submit an additional $50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.
No Form Schedule items changed.
No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Sara Farris

SERFF Tracking #:	*DDAR-128660188*	***State Tracking #:***		***Company Tracking #:***	*WS CERTS 12A*

State:	*Arkansas*	***Filing Company:***	*Delta Dental of Arkansas*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*WS dental certs*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:							
Item No.	**Schedule Item Status**	**Form Number**	**Form Type**	**Form Name**	**Action/ Action Specific Data**	**Readability Score**	**Attachments**
1	Approved-Closed 09/10/2012		POLA	DDPAR-WS_ 9618_9619_9620_ACTIVE CERT-12A	Initial:	34.500	DDPAR-WS_ 9618_9619_9620_ACTIVE CERT-12A.pdf
2	Approved-Closed 09/10/2012		POLA	DDPAR-WS RETIREE CERT-12A	Initial:	36.800	DDPAR-WS RETIREE CERT-12A.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, AR 72231
(501) 835-3400
(800) 462-5410
www.deltadentalar.com

CERTIFICATE OF COVERAGE

The coverage set out in this CERTIFICATE is offered to the group at the rates stated in and upon the terms and conditions set out in the employer CONTRACT. This includes all schedules, endorsements, APPLICATION AND AGREEMENT FOR EMPLOYERS, and amendments. Delta Dental of Arkansas (DDPAR) has caused this CERTIFICATE to be duly executed as of the service date confirmed by notice.

DELTA DENTAL OF ARKANSAS

BY: 

President

"Any person who knowingly presents a false or fraudulent CLAIM for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

TABLE OF CONTENTS

Congratulations! We are pleased that you selected Delta Dental of Arkansas (DDPAR) for your dental coverage. DDPAR is a leader in dental care – both in Arkansas and in the nation.

We are giving you this booklet that will explain the coverage and services provided under the group dental BENEFITS program sponsored by your employer. Complete details of your coverage are set out in the group CONTRACT. The CONTRACT is in your Employee Benefits Department.

Under your DDPAR program, you may seek services from any DENTIST you choose. However, INDIVIDUALs may receive a **higher level of BENEFITS by seeking care from a PARTICIPATING DENTIST.**

PARTICIPATING DENTISTs will complete and submit CLAIM FORMs for you at no charge. PARTICIPATING DENTISTs agree to accept the DDPAR MAXIMUM PLAN ALLOWANCE (MPA) for covered procedures. PARTICIPATING DENTISTs will not bill you for any amount over the MAXIMUM PLAN ALLOWANCE (MPA). Since we will pay the PROVIDER directly, you don't have to pay the entire bill and wait to be paid back.

If you visit a NON-PARTICIPATING DENTIST, you may have to complete the forms yourself or pay a service charge. You may have to pay the NON-PARTICIPATING DENTIST in advance for the entire bill. If so, DDPAR will pay any BENEFITS due to you after the CLAIM is submitted. Also, NON-PARTICIPATING DENTISTs have not agreed to accept the MAXIMUM PLAN ALLOWANCE (MPA) that DDPAR will pay. As a result, you will be responsible for any difference between the DENTIST's fee and the DDPAR payment. **Also, the benefit allowance for services of a NON-PARTICIPATING DENTIST may be reduced as indicated on your SCHEDULE OF BENEFITS for eligible services after applying the applicable DEDUCTIBLEs, co-payments, and maximums. This means your out-of-pocket expense may be more if you choose a NON-PARTICIPATING DENTIST.**

How do I select a DENTIST?
The easiest and most accurate listing of PROVIDERs is on our website. Click on our PROVIDER Directory link. Once at the web page, select the "Searching for a DENTIST" icon. From the "Product Selection" menu choose the network selected by your group as noted on your SCHEDULES OF BENEFITS (Delta Dental Premier or Delta Dental PPO). By entering the information requested, we will provide you with a list of PARTICIPATING DENTISTs in your area.

This booklet contains a summary in English of your plan rights and BENEFITS as a PARTICIPANT of your group's dental plan. If you have trouble understanding any part of this booklet, contact DDPAR's Customer Service Department at (800) 462-5410. Office hours are from 7:30 a.m. to 7:00 p.m. C.S.T., Monday through Friday.

Thank you for selecting Delta Dental of Arkansas. We look forward to serving you.

DELTA DENTAL OF ARKANSAS

CERTIFICATE OF COVERAGE

This CERTIFICATE OF COVERAGE (CERTIFICATE) gives your rights and duties as a Covered Person. Please read your CERTIFICATE carefully and be familiar with its terms.

The policy may require that the SUBSCRIBER pay part or all of the required PREMIUMs through your employer. You can get information regarding the PREMIUM and any part of the PREMIUM you may pay from your employer.

This policy is issued on the basis of the employer's APPLICATION and payment of the required PREMIUM. The APPLICATION is a part of the policy. Delta Dental of Arkansas will provide coverage to covered persons subject to the terms, conditions, exclusions, and limitations of the policy.

The policy takes effect on the date specified and will be continued in force by timely payment of the PREMIUMs when due. The policy is subject to termination as provided. All coverage under the policy will be effective at 12:01 a.m. and will end at 12:00 midnight C.S.T.

This CERTIFICATE is delivered in the State of Arkansas and is governed by the laws of the State of Arkansas.

ARTICLE 1. DEFINITIONS

As used in this CERTIFICATE:

The definitions of certain capitalized words used in this CERTIFICATE are set forth in this Article 1. Unless defined within the text of this CERTIFICATE or the context clearly denotes otherwise, these capitalized words will have the meaning set forth below.

"ANNUAL MAXIMUM BENEFIT" is the sum that DDPAR will pay for BENEFITS for any BENEFIT PERIOD.

"APPLICATION" is the form used for the GROUP SPONSOR to apply for coverage pursuant to the CONTRACT as provided by DDPAR.

"BENEFITS" means the sums that DDPAR will pay for limited-scope dental services under GROUP SPONSOR's CONTRACT as set out in this document, subject to the conditions, limitations, and restrictions set forth herein.

"BENEFIT PERIOD" is the twelve (12) month period during which BENEFITS are paid as set out in the SCHEDULE OF BENEFITS. This represents the accumulation period applicable to DEDUCTIBLEs, benefit maximums, and applicable time limits.

"CALENDAR YEAR" means the twelve (12) months beginning on January 1 and ending on December 31 of each year.

"CERTIFICATE OF COVERAGE (CERTIFICATE)" is a document evidencing that certain insurance coverage/protection is provided to a GROUP SPONSOR for the benefit of its subscribing ELIGIBLE EMPLOYEEs. This insurance protection is more specifically set out pursuant to the terms and conditions set out in the CONTRACT by and between the GROUP SPONSOR and DDPAR.

"CLAIM" means a request for BENEFITS under the CONTRACT made in accordance with the CONTRACT's procedures for filing benefit CLAIMs. A CLAIM includes a request for payment for a service, supply, prescription drug, equipment or TREATMENT covered by the CONTRACT. A CLAIM must be made in accordance with the CLAIMs procedures under the CONTRACT as set forth in CLAIMs procedure section of the CONTRACT. A CLAIM does not include any BENEFITS inquiries where such inquiries do not follow the requirements established in the CLAIMs procedures.

"CLAIMS ADMINISTRATOR" is Delta Dental of Arkansas (DDPAR).

"CLAIM FORM" is the standard dental form used to file a CLAIM or request PRE-DETERMINATION of BENEFITS issued by CLAIMS ADMINISTRATOR.

"COBRA" means Title X of Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272).

"COBRA-PARTICIPANT" is a PARTICIPANT who ceases to be eligible as a SUBSCRIBER or DEPENDENT but chooses to continue coverage as allowed for the time periods provided under COBRA.

"CODE" means the Internal Revenue CODE of 1986, as amended.

"CONTRACT" is the agreement between DDPAR and GROUP SPONSOR, including the APPLICATION, all schedules, endorsements, and amendments as issued by DDPAR.

"CONTRACT TERM" is the time commencing on the EFFECTIVE DATE plus any renewals or extensions while the CONTRACT is in effect. The CONTRACT TERM will end with the termination or cancellation of the CONTRACT.

"CONTRACT YEAR" is the twelve (12) months starting on the EFFECTIVE DATE and each subsequent twelve (12) months while the CONTRACT is in effect.

"DDPAR" is Delta Dental of Arkansas, an Arkansas Not-for-Profit Corporation. As used in this CERTIFICATE, DDPAR may refer to Delta Dental of Arkansas acting on its own behalf or acting on behalf of or in conjunction with a member or members of the Delta Dental Plans Association, DeltaUSA, or their successors and/or assigns.

"DEDUCTIBLE" is the amount the PARTICIPANT must pay for services in any BENEFIT PERIOD before certain BENEFITS will be paid under the CONTRACT, subject to limitations shown on the SCHEDULE OF BENEFITS.

"DELTA DENTAL PPO PLUS PREMIER" is a preferred provider organization that can reduce the out-of-pocket expenses for the SUBSCRIBER and ELIGIBLE DEPENDENTs if they receive care from one of DDPAR's PPO DENTISTs. This program has back-up coverage through DELTA DENTAL PREMIER when treatment is received from a NON-PPO DENTIST. (Please see the front page of the GROUP CONTRACT or the SCHEDULE OF BENEFITS for the network selected for your GROUP HEALTH PLAN.)

"DENTIST" is a person licensed to practice dentistry when and where services are performed.

- **"DELTA DENTAL PPO DENTIST"** is a dentist who has signed an agreement with DDPAR to be a preferred provider. The PPO dentist accepts DDPAR's payment and patient's payment, if any, as payment in full.
- **"DELTA DENTAL PREMIER DENTIST"** is a dentist who has signed an agreement with DDPAR to participate in DELTA DENTAL PREMIER. The PARTICIPATING DENTIST accepts DDPAR's payment and the patient's payment, if any, as payment in full.
- **"NON-PARTICIPATING DENTIST"** is a DENTIST who has not signed an agreement with DDPAR. It is the SUBSCRIBER's responsibility to make full payment to the NON-PARTICIPATING DENTIST.

"DEPENDENT" is as defined in Schedule E of the CONTRACT.

"DISCLOSURE" means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

"EFFECTIVE DATE" of this CONTRACT is 12:01 a.m. on the date coverage under the CONTRACT begins, as shown on the APPLICATION.

"ELIGIBLE DEPENDENT" is a DEPENDENT who meets the eligibility requirements as set forth in Schedule E of the CONTRACT.

"ELIGIBLE EMPLOYEE" is an EMPLOYEE who meets the eligibility requirements as set forth in Schedule E of the CONTRACT.

"EMPLOYEE" is an INDIVIDUAL employed by the GROUP SPONSOR.

"ENROLLMENT FORM" is the electronic system utilized by GROUP SPONSOR, or paper form submitted to apply for coverage for an ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENTs, if applicable under the CONTRACT between the GROUP SPONSOR and DDPAR.

"GROUP HEALTH PLAN" is the group dental BENEFITS program to which the CONTRACT applies.

"GROUP SPONSOR" is any individual, partnership, association, corporation, or organization which agrees to sponsor a group of ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs. It will pay or collect and remit by the due date to DDPAR the PREMIUMs payable by the members, either by payroll allotment or otherwise. It will also receive notice, CERTIFICATE, or rider from DDPAR on behalf of such members. The GROUP SPONSOR shall act only as agent of the group members. The GROUP SPONSOR shall not be the agent of DDPAR for any purpose.

"HEALTH INSURANCE ISSUER" means an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in the State of Arkansas and is subject to Arkansas law that regulates insurance.

"INDIVIDUAL" means a person who is the subject of PROTECTED HEALTH INFORMATION.

"INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION" is information that is a subset of health information, including demographic information collected from an INDIVIDUAL, and:

a) is created or received by a health care PROVIDER, health plan, group, or healthcare clearinghouse, and
b) relates to the past, present, or future physical or mental health or condition of an INDIVIDUAL, or the past, present, or future PAYMENT for the provision of health care to an INDIVIDUAL, and
c) that identifies an INDIVIDUAL, or
d) with respect to which there is a reasonable basis to believe the information can be used to identify the INDIVIDUAL.

"MAXIMUM PLAN ALLOWANCE" is the maximum payment allowed by DDPAR for the applicable covered service(s) provided by the DENTIST(s).

"NON-PARTICIPATING DENTIST" is any DENTIST other than a PARTICIPATING DENTIST.

"PARTICIPANT" is an ELIGIBLE EMPLOYEE or an ELIGIBLE DEPENDENT who is enrolled under the CONTRACT.

"PARTICIPATING DENTIST" or "NETWORK PROVIDER" is a licensed DENTIST who has contracted with and agreed to abide by the rules and regulations of DDPAR or any other organization that is a member of Delta Dental Plans Association, DeltaUSA, or its affiliates.

"PLAN ADMINISTRATOR" is the administrator of the CONTRACT, which is the GROUP SPONSOR.

"PRE-DETERMINATION" is an opinion from DDPAR as to payments that would be made by DDPAR as reasonably necessary for anticipated TREATMENT of a PARTICIPANT. The opinion is based upon information forwarded to DDPAR. It does not guarantee such payment in that actual payment would also depend on applicable coverage being in effect at the time any such services were rendered. The payment may also be subject to DEDUCTIBLE, co-insurance, and maximum BENEFITS allowed. Similar terms also used for PRE-DETERMINATION are pre-authorization, prior-authorization, pre-TREATMENT review, and/or, pre-certification. A PARTICIPANT, however, is not required to seek a PRE-DETERMINATION for any TREATMENT under this CERTIFICATE.

"PRE-EXISTING CONDITION" means the state or condition of the mouth that exists prior to the patient's EFFECTIVE DATE of COVERAGE under this CERTIFICATE.

"PREMIUM" is the monthly amount to be paid, as agreed, by GROUP SPONSOR to DDPAR for coverage under the CONTRACT.

"PROTECTED HEALTH INFORMATION" (PHI) shall have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations. PHI means INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION:

a) that is:
    1) transmitted by electronic media,
    2) maintained in any medium described in the definition of electronic media pursuant to HIPAA and/or related regulations, or
    3) transmitted or maintained in any other form or medium.
b) PROTECTED HEALTH INFORMATION excludes INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION in education records covered by the Family Educational Right and Privacy Act.

"PROVIDER" means a legally licensed DENTIST or any other legally licensed dental practitioner rendering services. Services must be covered under the CONTRACT and be within the scope of the DENTIST or other legally licensed dental practitioner's license.

"QUALIFYING EVENT" means the occurrence of a specified event that would allow an ELIGIBLE EMPLOYEE and/or ELIGIBLE DEPENDENT to enroll in coverage or drop coverage after the eligibility date and at a time other than the annual enrollment period.

"REQUIRED BY LAW" means a mandate contained in law that compels a covered entity to make a use or DISCLOSURE of PROTECTED HEALTH INFORMATION and that is enforceable in a court of law. REQUIRED BY LAW includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general; or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care PROVIDERs participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public BENEFITS.

"SCHEDULE OF BENEFITS" is the document that lists the BENEFITS that will be provided a PARTICIPANT. Such SCHEDULE OF BENEFITS shall be the one in effect and for which dental PREMIUMs are remitted at the time dental care is provided.

"SUBSCRIBER" is an ELIGIBLE EMPLOYEE who is enrolled in the CONTRACT.

"TOTALLY DISABLED" means, in the case of a DEPENDENT child, the complete inability, as a result of illness or injury, to perform the normal activities of a person of like age and sex in good health, as certified by the Social Security Administration.

"TREATMENT" means the provision, coordination, or management of health care and related services by one or more health care PROVIDERs. This includes the coordination or management of health care by a health care PROVIDER with a third party, consultation between health care PROVIDERs relating to a patient, or the referral of a patient for health care from one health care PROVIDER to another.

"TREATMENT PLAN" is a written report showing the recommended TREATMENT of any dental disease, defect, or injury for a PARTICIPANT prepared by a DENTIST as a result of any examination made by such DENTIST while coverage under the CONTRACT is in effect for the PARTICIPANT.

"URGENT CARE" involves medical care or TREATMENT that is necessary and reasonable and if not provided:

a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
b) In the opinion of a physician with knowledge of the claimant's medical condition would subject the claimant to severe pain that cannot be adequately managed without the care or TREATMENT that is the subject of the CLAIM.

"USE" means, with respect to INDIVIDUALLY IDENTIFIABLE HEALTH INFORMTION, the sharing, employment, application, utilization, examination, or analysis of information within an entity that maintains such information.

"USERRA" means the Uniform Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT

2.01 ELIGIBLE EMPLOYEES. All active, full-time EMPLOYEE(s) of the GROUP SPONSOR working the designated number of hours per week on the EFFECTIVE DATE will be eligible to enroll for coverage under the CONTRACT. All other EMPLOYEE(s) will be eligible to enroll for coverage on the first day of the calendar month after they have completed their applicable probationary period. EMPLOYEES classified by the GROUP SPONSOR as temporary, seasonal, or leased, will not be eligible to enroll for coverage under this CERTIFICATE.

The probationary period shall be as defined by the APPLICATION or as amended by the GROUP SPONSOR.

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The eligibility date for ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs shall be the first day of the calendar month following the completion of the probationary period or as specified by the GROUP SPONSOR.

2.02 INITIAL PLAN ENROLLMENT. ELIGIBLE EMPLOYEE(s) and their ELIGIBLE DEPENDENT(s) must enroll for coverage during the ELIGIBLE EMPLOYEE'S first sixty (60) days of employment, or within thirty-one days (31) days of a QUALIFYING EVENT or as otherwise described below, or during an annual enrollment, or as otherwise allowed by the GROUP.

QUALIFYING EVENTs that allow an ELIGIBLE EMPLOYEE to enroll in coverage, drop coverage, or add/drop ELIGIBLE DEPENDENTS include any of the following:

a) an individual becomes an ELIGIBLE DEPENDENT of the ELIGIBLE EMPLOYEE through marriage, birth, adoption, placement for adoption, establishment of legal wardship or guardianship; or
b) an ELIGIBLE EMPLOYEE experiences a divorce, legal separation, or annulment; or
c) a DEPENDENT of the ELIGIBLE EMPLOYEE dies; or
d) an ELIGIBLE EMPLOYEE or DEPENDENT commences or terminates employment or gains or loses coverage under another health plan or dental insurance; or
e) an EMPLOYEE changes employment status and becomes an ELIGIBILE EMPLOYEE; for instance, moving from under 20 regular hours a week to 20+ regular hours a week, or moving from a non-eligible union to an eligible union or non-bargaining employment status; or
f) an ELIGIBLE EMPLOYEE returns from an unpaid leave of absence, or
g) an ELIGIBLE EMPLOYEE has been rehired within 31 days of termination; or a RETIREE has been rehired;
h) an ELIGIBLE EMPLOYEE may make a change in coverage to correspond with a spouse's, domestic partner's, or family member's coverage change under another employer's health or dental plan due to marriage, divorce, death, birth/adoption/legal guardianship, loss of eligibility status or if the other plan's plan year is different than Windstream's plan year; or
i) an ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT becomes eligible for apremium assistance subsidy under Medicaid or a State Children's Health Insurance Program ("CHIP"); or
j) an ELIGIBLE EMPLOYEE's or ELIGIBLE DEPENDENT's coverage under Medicaid or a State Children's Health Insurance Program ("CHIP") is terminated due to loss of eligibility. ELIGIBLE EMPLOYEE must request coverage within sixty (60) days after receipt of a determination letter from Medicaid or CHIP).

ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs must enroll for coverage within thirty-one (31) days from the QUALIFYING EVENT. Notwithstanding the foregoing, if the QUALIFYING EVENT results from the birth or adoption of a child, and the child is under the age of three (3), the child may be enrolled, as applicable, at any time until the first of the calendar month following the child's third (3rd) birthday.

Coverage for an adopted child shall begin on the date of the filing of a petition for adoption if the ELIGIBLE EMPLOYEE applies for coverage within sixty (60) days after the filing of the petition for adoption. However, the coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the child.

An ENROLLMENT FORM shall be completed to enroll any newly ELIGIBLE DEPENDENTs even if SUBSCRIBER already has selected DEPENDENT coverage under the CONTRACT. If no ENROLLMENT FORM is submitted to DDPAR within thirty-one (31) days from the ENROLLMENT QUALIFYING EVENT, no coverage will be provided under the CONTRACT on behalf of the ELIGIBLE DEPENDENT and ELIGIBLE EMPLOYEE, as applicable.

2.03 ANNUAL ENROLLMENT PERIOD. ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs who do not enroll for coverage on a timely basis upon initial eligibility or upon an ENROLLMENT QUALIFYING EVENT will be permitted to enroll for coverage under the CONTRACT during annual enrollment or as allowed by the group. The PLAN ADMINISTRATOR will establish an annual enrollment period prior to the beginning of each CONTRACT YEAR. Coverage begins on January 1.

2.04 ELIGIBLE DEPENDENTS. ELIGIBLE DEPENDENTs include SUBSCRIBER's legally married spouse (not legally separated), same sex domestic partner as defined by the GROUP and each child who is the age specified in the APPLICATION or younger. Such DEPENDENT must be a resident of the United States. Under certain circumstances, the SUBSCRIBER may be required to provide PLAN ADMINISTRATOR or DDPAR with proof of the SUBSCRIBER/DEPENDENT relationship.

The term child means a) a natural born child, b) a stepchild, c) an adopted child or a child lawfully placed with you for adoption, d) a child for whom the ELIGIBLE EMPLOYEE is the legal guardian, or e) a child for whom the ELIGIBLE EMPLOYEE is legally required to provide medical coverage, or f) same-sex domestic partner's children, if those children are listed on the ELIBIGLE EMPLOYEE's federal tax return as a DEPENDENT. An ELIGIBLE EMPLOYEE'S grandchild is eligible only if the ELIGIBLE EMPLOYEE's child (who is the parent of the grandchild and is an ELIGIBLE DEPENDENT) is enrolled in the plan and the grandchild lives in the same residence and is dependent on the ELIGIBLE EMPLOYEE for support (grandchild or the parent of the grandchild must be listed on the ELIGIBLE EMPLOYEE's federal tax return as a DEPENDENT.)

For Louisiana state residents, grandchildren up to age 26 are eligible if the ELIGIBLE EMPLOYEE has legal custody of the grandchild and the grandchild resides with the ELIGIBLE EMPLOYEE. The grandchild may be eligible regardless of student or marital status. Grandchildren age 26 or over who are incapable of self-support because of a disability and were

covered under the Windstream plans prior to reaching the limiting age of 26 may be able to continue coverage subject to annual recertification.

No individual may be covered under this PLAN as both an EMPLOYEE and a DEPENDENT. Also, no individual will be considered an ELIGIBLE DEPENDENT of more than one EMPLOYEE.

If a DEPENDENT child, upon reaching age twenty-six (26), is TOTALLY DISABLED and resides with the SUBSCRIBER, such DEPENDENT child will continue to be an ELIGIBLE DEPENDENT under the CONTRACT until such time as the DEPENDENT child is no longer TOTALLY DISABLED or coverage under the CONTRACT terminates for any reason.

The EMPLOYEE will be required to provide DDPAR or GROUP SPONSOR with written evidence of a DEPENDENT child's disability status.

2.05 **EFFECTIVE DATE OF COVERAGE.** Coverage for an ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT who timely enrolls will be effective on whichever of the following occurs first:

a) IBEW 1671 ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT will be effective on 1st of the month following 60 days of employment, provided ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT enroll within sixty (60) days of employment. Effective September 1, 2012, IBEW 1671 ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT will be effective on 1st of the month following 90 days of employment, provided ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT enroll within sixty (60) days of employment.

Non-Bargaining ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT and union ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT in CWA 3174, 3371, 3372, 7470, 74701, 6171, 617101, 4488, 4321, 4485, 13000, 10300, 10800, 10500, 10900, 3683, 3684, 3716, 3511, and IBEW 0463, 1189, 1929, 2089, 2374, 150701, 150710, will be effective on the 1st of the month following 90 days of employment, provided the ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT enrolls within sixty (60) days of employment.

CWA 7172 and IBEW 204 ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs will be effective on the 91st date of employment, provided the ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs enroll within sixty (60) days of employment.

c) On the event date of a QUALIFYING EVENT, provided ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs enroll within thirty one (31) days from the QUALIFYING EVENT unless otherwise specified in 2.02(j), or unless the QUALIFYING EVENT is a divorce, legal separation, or annulment as specified in 2.02(b). If the ELIGIBLE EMPLOYEE experiences a QUALIFYING EVENT of divorce, legal separation, or annulment, then the newly enrolled coverage becomes effective on the 1st day of the month following the QUALIFYING EVENT.

d) On the event date of a QUALIFYING EVENT, ELIGIBLE DEPENDENTs enroll within thirty one (31) days from the QUALIFYING EVENT unless otherwise specified in 2.02(j).

e) As of the first day of the plan year following the annual enrollment period, if the ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs enrolls for coverage during the annual enrollment period.

2.06 The PARTICIPANT will be allowed to continue BENEFITS during a PARTICIPANT's unpaid leave of absence as determined by the policy of the GROUP SPONSOR. If it is the policy of the GROUP SPONSOR not to continue BENEFITS for an unpaid leave of absence, the PARTICIPANT will not have coverage during this leave. Coverage will resume on the date the EMPLOYEE returns to work.. PARTICIPANTs may continue coverage under COBRA, if applicable, or an applicable state continuation of coverage provision when the EMPLOYEE is on strike or layoff.

2.07 If it is the policy or legal responsibility of the GROUP SPONSOR to continue coverage during a leave of absence, the GROUP SPONSOR will be responsible for the timely payment of all PREMIUMs due to DDPAR for the EMPLOYEE on leave of absence.

2.08 An EMPLOYEE loses coverage when employment BENEFITS are terminated by the GROUP SPONSOR at the end of the month employment is terminated, when applicable PREMIUM(s) are not paid/received, when EMPLOYEE loses eligibility, or at the end of the CONTRACT. DEPENDENT(s) will lose coverage along with the EMPLOYEE or earlier if DEPENDENT loses his or her DEPENDENT status.

2.09 Possession of an identification card does not guarantee a PARTICIPANT is eligible for BENEFITS. Eligibility is based on information reported to DDPAR by the group. Eligibility may be confirmed by calling DDPAR's Customer Service Representatives, but the card **is not a guarantee of payment.**

2.10 DDPAR will not continue to pay BENEFITS for any PARTICIPANT(s) when they lose eligibility upon notification from the GROUP SPONSOR. As provided by COBRA, USERRA, or any applicable state continuation of coverage provision, if applicable, the EMPLOYEE's coverage may continue for up to eighteen (18) months where the EMPLOYEE's coverage ends as a result of a reduction in work hours or termination of employment in accordance with and pursuant to such provisions. Coverage may not continue if the termination is the result of gross misconduct.

Under COBRA, or an applicable state continuation of coverage provision, DEPENDENTs may continue coverage under this CONTRACT for up to thirty-six (36) months.

The following are qualifying events that allow a DEPENDENT to continue coverage if they cause the DEPENDENT to lose coverage

- Termination of the EMPLOYEE's employment for any reason other than "gross misconduct";
- Reduction in hours worked by the EMPLOYEE;
- The EMPLOYEE becomes entitled to Medicare;
- Divorce or legal separation of the spouse from the EMPLOYEE; or
- Death of the EMPLOYEE.

In addition, a DEPENDENT child may continue coverage if the child is ineligible for Medicare and ceases to meet the definition of "DEPENDENT."

In any case, coverage shall end if the PARTICIPANT fails to pay the required PREMIUM to the GROUP SPONSOR, becomes eligible for Medicare, obtains other group coverage, or the GROUP SPONSOR cancels group dental coverage.

If applicable, PARTICIPANTs must choose whether or not to continue their coverage. PARTICIPANTs have sixty (60) days to make such an election. The sixty (60) day period shall start at the earlier of the date the PARTICIPANT's coverage would otherwise end or the date the PARTICIPANT receives notice of his/her rights. **GROUP SPONSOR should terminate PARTICIPANT's coverage until election is made and PAYMENT is received.** Coverage will be reinstated with no break.

EMPLOYEE is responsible for notifying the GROUP SPONSOR immediately of any change(s) in eligibility. EMPLOYEE should tell GROUP SPONSOR of changes in DEPENDENT status, divorce, or eligibility for Medicare.

Pursuant to USERRA, GROUP SPONSOR must provide certain reemployment and benefit rights to EMPLOYEEs who take a leave of absence for military service. ELIGIBLE EMPLOYEEs who meet the requirements under USERRA are generally entitled to reemployment upon their return from uniformed service and to reinstatement and continuation of their employment BENEFITS.

An ELIGIBLE EMPLOYEE who is absent from employment in order to serve in the uniformed services, as well as his or her ELIGIBLE DEPENDENTs, may elect to continue health coverage during the period of uniformed service, if applicable. The maximum length of the continuation coverage required under USERRA is the lesser of:

a) twenty four (24) months (beginning on the day that the uniformed service leave commences), or
b) a period beginning on the day the uniformed service leave commences and ending on the day such leave ends.

If a PARTICIPANT elects to continue health coverage pursuant to USERRA, such PARTICIPANT will be required to pay 102% of the full PREMIUM for the coverage elected. However, if the uniformed service leave of absence is less than thirty-one (31) days, the PARTICIPANT will not be required to pay more than the PARTICIPANT would have been required to pay if PARTICIPANT had not been on uniformed service leave.

A PARTICIPANT whose coverage was terminated during the period of uniformed service shall not be subject to any exclusions or restrictions for PRE-EXISTING CONDITIONS upon reinstatement of the health coverage under the CONTRACT if an exclusion would not have been imposed under the CONTRACT had coverage not been terminated by reason of the uniformed service. However, CONTRACT exclusions may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

It shall be PLAN ADMINISTRATOR's sole responsibility to ensure that all COBRA, USERRA, or any other applicable state continuation of coverage provisions are complied with.

2.11 TAKE OVER PROVISIONS. Within sixty (60) days from the date of the end of a prior plan, DDPAR will cover all ELIGIBLE EMPLOYEEs and DEPENDENTs:

a) If each EMPLOYEE or DEPENDENT was validly covered under the previous plan at the date of the end of the plan.
b) If each EMPLOYEE or DEPENDENT is a member of the class of INDIVIDUALs eligible for coverage under the prior carrier's plan, regardless of any of the plan's limitations or exclusions related to "actively at work" or hospital confinement.
c) Only if the group accident and health BENEFITS were provided to a group consisting of more than fifteen (15) members.

The succeeding carrier should be entitled to deduct from its BENEFITS any BENEFITS payable by the prior carrier pursuant to an extension of BENEFITS provision.

No provision in a succeeding carrier's plan of replacement coverage which would operate to reduce or exclude BENEFITS on the basis the condition giving rise to BENEFITS pre-existed the EFFECTIVE DATE of the succeeding carrier's plan shall be applied with respect to those ELIGIBLE EMPLOYEEs and DEPENDENTs validly insured under the previous carrier's policy on the date of discontinuance, and only if BENEFITS for the condition would have been payable under the previous carrier's plan.

This will apply upon the issuance of an insurance policy or health care plan:

a) To a group whose BENEFITS had previously been self-insured.
b) To a self-insurer providing coverage to a group which had been previously covered by an insurer.
c) To a group which had been previously covered by an insurer.

ARTICLE 3. EXCLUSIONS FOR ALL BENEFITS

3.01 DDPAR will only pay the BENEFITS stated for each type of dental service set out in the SCHEDULE OF BENEFITS. **Not all dental services are BENEFITS under the CONTRACT**. BENEFITS will only be provided for PARTICIPANTs who are enrolled on the date of TREATMENT. BENEFITS will be determined based on the date services were rendered. Services must be provided by a DENTIST or properly licensed EMPLOYEE of the DENTIST. Services must be necessary and customary. Services must be provided following generally accepted dental practice standards as determined by the dental profession to be a paid benefit. DDPAR will pay allowable BENEFITS based upon the percentages and subject to the ANNUAL MAXIMUM BENEFIT as stated in the SCHEDULE OF BENEFITS. Such percentages will be applied to the lesser of the MAXIMUM PLAN ALLOWANCE (MPA) or the fees the DENTIST charges for the service. **The maximum payment for NON-PARTICIPATING DENTISTs may be less than to a PARTICIPATING DENTIST, please refer to your SCHEDULE OF BENEFITS.** Payments for covered services by NON-PARTICIPATING DENTISTs will be sent to the patient(s). NON-PARTICIPATING DENTISTs may balance-bill patients for the difference of their charges and DDPAR's payment. PARTICIPATING DENTISTs shall not balance-bill patients for charges in excess of the MPA for covered BENEFITS under the CONTRACT.

3.02 OPTIONAL SERVICES

a) Services that cost more than the TREATMENT usually provided under accepted dental practice standards are called Optional Services. Optional Services also include the use of specialized instead of standard procedures. BENEFITS for Optional Services will be based on the cost of the standard service. The PARTICIPANT will be responsible for the remainder of the DENTIST's fee.
b) Payment made by DDPAR for any surgical service will include charges for routine, post-operative evaluations or visits.
c) If a PARTICIPANT transfers from one DENTIST to another during the course of TREATMENT, BENEFITS will be limited to the amount that would have been paid if one DENTIST rendered the service.

3.03 EXCLUSIONS

DDPAR does not pay BENEFITS for:

a) BENEFITS or services for injuries or conditions covered under Worker's Compensation or Employer's Liability laws. BENEFITS or services available from any federal or state government agency; municipality, county, other political subdivision; or community agency; or from any foundation or similar entity.
b) Charges for services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
c) Charges for services or supplies for which no charge is made that the patient is legally obligated to pay. Charges for which no charge would be made in the absence of dental coverage.

d) Charges for TREATMENT by other than a DENTIST except that a licensed hygienist may perform services in accordance with applicable law. Services must be under the supervision and guidance of the DENTIST in accordance with generally accepted dental standards.
e) Charges for the completion of forms and/or submission of supportive documentation required by DDPAR for a benefit determination. A charge for these services is not to be made to a DDPAR-covered patient by a PARTICIPATING DENTIST.
f) BENEFITS to correct congenital or developmental malformations.
g) Services for the purpose of improving appearance when form and function are satisfactory, and there is insufficient pathological condition evident to warrant the TREATMENT (cosmetic dentistry).
h) BENEFITS for services or appliances started prior to the date the patient became eligible under this plan, including, but not limited to, restorations, prosthodontics, and orthodontics.
i) Services with respect to diagnosis and TREATMENT of disturbances of the temporomandibular joint (TMJ), unless optional coverage is purchased.
j) Services for increasing the vertical dimension or for restoring tooth structure lost by attrition, for rebuilding or maintaining occlusal services, or for stabilizing the teeth.
k) Experimental and/or investigational services, supplies, care and TREATMENT which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards or a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered. The CLAIMS ADMINISTRATOR must make an independent evaluation of the experimental or non-experimental standings of specific technologies. The CLAIMS ADMINISTRATOR's decision will be final and binding on the CONTRACT. Drugs are considered experimental if they are not commercially available for purchase and/or are not approved by the Food and Drug Administration for general use.
l) Charges for replacement of lost, missing, or stolen appliances/devices.
m) Charges for services when a CLAIM is received for payment more than twelve (12) months after services are rendered.
n) Charges for complete occlusal adjustments, occlusal guards, occlusion analysis, enamel microabrasion, odontoplasty, bleaching, and athletic mouthguards, unless noted specifically in the SCHEDULE OF BENEFITS
o) Specialized techniques that entail procedure and process over and above that which is normally adequate. Any additional fee is the patient's responsibility.
p) Behavior management.
q) Those services and BENEFITS excluded by the rules and regulations of DDPAR, including DDPAR's processing policies.
r) Removable appliances for control of harmful habits, including but not limited to tongue thrust appliances.
s) s) Procedures that do not comply with DDPAR's guidelines.
t) Charges for precision attachments, provisional splinting, desensitizing medicines, home care medicines, premedications, stress breakers, coping, office visits during or after regularly scheduled hours, case presentations, and hospital-related services.
u) All other BENEFITS and services not specifically covered in the CONTRACT and/or SCHEDULE OF BENEFITS.

ARTICLE 4. DEDUCTIBLE, MAXIMUM, AND COORDINATION OF BENEFITS

4.01 DDPAR will not pay BENEFITS until the annual DEDUCTIBLE amount has been satisfied, unless the covered procedure is not subject to the DEDUCTIBLE. The DEDUCTIBLE will apply as listed on the SCHEDULE OF BENEFITS.

4.02 The DEDUCTIBLE applies to the BENEFITS as shown on the SCHEDULE OF BENEFITS. Only fees a PARTICIPANT pays for services covered under the benefit schedules in this CERTIFICATE will count toward satisfying the DEDUCTIBLE.

4.03 Unless otherwise listed on the SCHEDULE OF BENEFITS, the DEDUCTIBLE and maximums apply to each BENEFIT PERIOD.

4.04 COORDINATION OF BENEFITS
If a PARTICIPANT is entitled to coverage under more than one insurance policy or benefit program, the BENEFITS of this CERTIFICATE will be subject to the following conditions:

a) If the other program is not primarily a dental program, this program is primary.
b) If the other program is for dental coverage, the following rules apply:
    1) The program covering the patient as an EMPLOYEE is primary over a program covering the patient as a DEPENDENT.
    2) Where the patient is a DEPENDENT child, primary dental coverage will be determined as follows:
        i) The coverage of the parent whose date of birth occurs earlier in the CALENDAR YEAR will be primary.

ii) Except for a DEPENDENT child of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent's spouse (i.e., stepparent) will be primary, unless there is a court decree stating that one parent has financial responsibility for a child's health care expenses. If so, any DEPENDENT coverage of that parent will be primary to any other DEPENDENT coverage.

c) When primary coverage cannot be determined according to a) and b), the program that has covered the patient for the longer period will be primary.

d) Coordination of BENEFITS within the same group will not be allowed.

If this coverage is primary, BENEFITS will be provided without regard to any other coverage. If this coverage is not primary, BENEFITS are limited to services which are BENEFITS of this CONTRACT that are not fully paid by any other coverage. However, BENFITS can not exceed the amount of actual charges for any service(s).

ARTICLE 5. CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

5.01 **CHOICE OF DENTIST**. DDPAR does not furnish covered services directly. DDPAR pays for licensed DENTISTs to provide these services. A PARTICIPANT may choose any DENTIST. PARTICIPANTs should determine the qualifications of the DENTIST they select. Participation in DDPAR is open to all DENTISTs who meet DDPAR's standards and who are licensed in Arkansas unless they have previously had their participation in DDPAR terminated. DDPAR only controls credentialing in Arkansas. However, there is currently in effect a policy by Delta Dental Plans Association (National), which is applicable to DeltaUSA groups. This policy requires all Delta Plans to have credentialing. Other state's credentialing policies are available upon request. Whether a DENTIST is a PARTICIPATING or NON-PARTICIPATING DENTIST should not be viewed as a statement about that DENTIST's abilities.

DDPAR shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, DDPAR cannot ensure your DENTIST's use of precautions against the spread of such diseases. Also, DDPAR cannot compel your DENTIST to be tested for HIV or to disclose test results to DDPAR or to a PARTICIPANT. If there are questions about your DENTIST's health status or use of recommended clinical precautions, PARTICIPANT should discuss them with the DENTIST.

5.02 **CLINICAL EXAMINATION**. Before approving a CLAIM, DDPAR may obtain from any DENTIST or hospital such information and records DDPAR may require to administer the CLAIM. DDPAR may require that a PARTICIPANT be examined by a dental consultant, retained by DDPAR, in or near his/her place of residence.

5.03 **PRE-DETERMINATION**. A DENTIST may file a CLAIM FORM showing the services he or she recommends. DDPAR will then pre-determine the BENEFITS payable under this CONTRACT. PAYMENT will only be made for pre-determined services if the PARTICIPANT receives TREATMENT for which BENEFITS are payable, remains eligible, and has not exceeded his or her ANNUAL MAXIMUM BENEFITS. A CLAIM FORM requesting a PRE-DETERMINATION may be submitted electronically.

5.04 **TREATMENT OF BENEFITS ON LACK OF ELIGIBILITY**. DDPAR will not pay BENEFITS for any services received by a patient who is not eligible at the time of TREATMENT. GROUP SPONSOR will repay DDPAR, limited to the monthly PREMIUM, for any payments due to errors or delays in reporting by the GROUP SPONSOR.

5.05 **TO WHOM BENEFITS ARE PAID**. BENEFITS provided under this CONTRACT will be paid as follows:

a) For services provided by a PARTICIPATING DENTIST, payment will be made to the PARTICIPATING DENTIST.

b) For services provided by a NON-PARTICIPATING DENTIST, payment will be made to SUBSCRIBER. The SUBSCRIBER is responsible for all payments to a NON-PARTICIPATING DENTIST.

ARTICLE 6. CLAIMS PROCEDURES

6.01 **CLAIMS**. CLAIMs must be filed by PARTICIPANT or PARTICIPANT's authorized representative with DDPAR within twelve (12) months after completion of TREATMENT for which BENEFITS are payable. Any CLAIM filed after this period will be denied. The CLAIMS ADMINISTRATOR has complete discretion to interpret the terms of the BENEFITS under the CONTRACT and such interpretation shall be final and conclusive.

6.02 **FILING CLAIMS/PARTICIPATING DENTISTS.** PARTICIPATING DENTISTS will complete and submit CLAIM FORMs for PARTICIPANTS at no charge. PARTICIPATING DENTISTS may ask PARTICIPANTs to fill out the patient section of the CLAIM FORM, which includes the SUBSCRIBER's name, social security number (SSN), and address; the PARTICIPANT's name, date of birth, and relationship to SUBSCRIBER; and coordination of BENEFITS information, if applicable.

6.03 FILING CLAIMS/NON-PARTICIPATING DENTISTS. If the PARTICIPANT visits a NON-PARTICIPATING DENTIST, PARTICIPANT may be required to complete the CLAIM FORM or pay a service charge. The patient section should be completed, which includes the SUBSCRIBER's name, SSN, and address; the PARTICIPANT's name, date of birth, and relationship to SUBSCRIBER, and coordination of BENEFITS information, if applicable.

PARTICIPANT will also be responsible for ensuring the NON-PARTICIPATING DENTIST completes the DENTIST and the Diagnostic (TREATMENT) Sections of the CLAIM FORM. The DENTIST Section includes the DENTIST's name, address, SSN or TIN number, license number, and phone number. The DENTIST must also indicate whether x-rays are attached and answer questions regarding TREATMENT that is the result of an accident. The DENTIST must also indicate if dentures, bridges, and crowns are replacements, and if so, the date of prior placement and reason for replacement must be noted.

The Diagnostic Section (TREATMENT) includes services performed (name description and ADA procedure code), including date of service, fee for service, and if applicable, tooth number or letter and tooth surface. For any unusual services, the Remarks Section of the CLAIM FORM must give a brief description. The CLAIM FORM needs to be signed by the DENTIST who performed the services and by the SUBSCRIBER/PARTICIPANT.

6.04 PROCESSING THE CLAIM. If PARTICIPANT visits a PARTICIPATING DENTIST, upon receipt of the CLAIM, it will be processed according to the GROUP SPONSOR's CONTRACT BENEFITS. For PARTICIPANTS who visit a PARTICIPATING DENTIST, notification of the benefit determination will be sent to the SUBSCRIBER in the form of an Explanation of BENEFITS, which details by service rendered what the CONTRACT allowed and the PARTICIPANT's obligation, if any.

If PARTICIPANT visits a NON-PARTICIPATING DENTIST, the SUBSCRIBER will receive a CLAIM Payment Statement, which will detail by service rendered what the CONTRACT allowed and the PARTICIPANT's obligation, if any. The CLAIM Payment Statement will also include a benefit check made payable to the SUBSCRIBER.

6.05 INITIAL CLAIM DETERMINATION. If the CLAIMS ADMINISTRATOR denies all or a portion of the CLAIM, PARTICIPANT will receive an Explanation of BENEFITS (for PARTICIPANTs visiting a PARTICIPATING DENTIST) or a CLAIM Payment Statement (for PARTICIPANTs visiting a NON-PARTICIPATING DENTIST) indicating the reason for the denial. The denial explanation will be printed at the bottom of the page.

The SUBSCRIBER will be notified within thirty (30) days of the receipt of the CLAIM by CLAIMS ADMINISTRATOR of the benefit determination.

In the case of an URGENT CARE CLAIM, the SUBSCRIBER will be notified within seventy-two (72) hours from the time the CLAIM is received by the CLAIM ADMINISTRATOR of the benefit determination.

6.06 APPEAL OF DENIED CLAIM. If the CLAIMS ADMINISTRATOR has denied a CLAIM, claimant may appeal the denial. Both the claimant and CLAIMS ADMINISTRATOR must take the following steps to complete an appeal (decision review):

a) Procedures the PARTICIPANT or PARTICIPANT's attending DENTIST Must Follow:
   1) Write to the CLAIMS ADMINISTRATOR at the following address: Customer Service Support, [Post Office Box 15965, North Little Rock, Arkansas, 72231] within one-hundred-eighty days (180) of the date on the notice of PARTICIPANT's CLAIM denial.
   2) State why the CLAIM should not have been denied.
   3) Include the denial notice and any other documents, data information, or comments that claimant believe may have an influence on the appeal of the CLAIM.
   4) If requested, claimant will receive, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied CLAIM.
   5) For an expedited review of an URGENT CARE CLAIM, the request may be submitted orally (by telephone) or in writing (by facsimile or another similarly expeditious method).
b) Procedures CLAIMS ADMINISTRATOR must follow for a full and fair appeal:
   1) Identify the medical or vocational experts whose advice was obtained and utilized on behalf of CLAIMS ADMINISTRATOR in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.
   2) Not consider the initial denial in the review.
   3) Conduct a review that includes one or more of the members of the CLAIMS ADMINISTRATOR's Appeals Committee (to be determined at the sole discretion of CLAIMS ADMINISTRATOR), but in no event will the individual who made the initial CLAIM denial, nor the subordinate of that individual be part of the review.

4) Consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted initially, nor who is the subordinate of such individual if your denial is based in whole or in part on a medical judgment, including determinations with regard to whether a particular TREATMENT, drug, or other item is experimental, investigational, or not medically necessary or appropriate.

c) Procedures CLAIMS ADMINISTRATOR must follow to notify claimant of its decision (if adverse):
   1) Provide claimant with a notice that includes the following information, to wit:
      i) The specific reason(s) for the adverse determination.
      ii) Reference to the specific CONTRACT provision(s) on which the adverse determination is based.
      iii) A statement that claimant is entitled to receive, free of charge, access to and copies of all information relevant to the CLAIM.
      iv) A statement describing any voluntary appeal procedures, if any, and a statement of claimant's right to bring an action under section 502 (a) of the EMPLOYEE Retirement Income Security Act.
      v) A statement that any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination will be provided free of charge upon request..
      vi) If adverse determination is based on a medical necessity or experimental TREATMENT, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.
      vii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."
   2) Provide claimant with the aforementioned notice within seventy-two (72) hours if the CLAIM is an URGENT CARE CLAIM.
   3) Provide claimant with the aforementioned notice within sixty (60) days if the CLAIM is a post-service CLAIM.

ARTICLE 7. DELTA DENTAL OF ARKANSAS PRIVACY POLICY STATEMENT FOR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Protecting your privacy is a priority of DDPAR. The purpose of this statement is to help you understand how DDPAR uses and protects your INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

7.01 INFORMATION DDPAR RECEIVES

DDPAR receives INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION about you from the following sources:

a) Information we receive from you on applications and other forms or from your group dental plan or employer and from our agents, PROVIDERs, and PLAN ADMINISTRATORs;
b) Information you provide to DDPAR in order to receive our services;
c) Information about your transactions with us, our affiliates, or others; and,
d) Information we receive from a DENTIST who provides dental services to you.

7.02 HOW INFORMATION IS USED AND DISCLOSED

DDPAR does not sell the INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION of its customers or former customers to any unaffiliated third parties. Such information is used for underwriting and processing your claim. This information is only provided to third parties under certain circumstances. The INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION DDPAR collects, as described above, may be disclosed as follows:

a) For TREATMENT, payment, and HEALTH CARE OPERATIONS as defined under HIPAA with respect to DDPAR's administration of your dental BENEFITS program.
b) For the proper management and administration of DDPAR.
c) To provide data aggregation services to your GROUP HEALTH PLAN.
d) If applicable, to your employer's EMPLOYEEs, classes of EMPLOYEEs, or other persons identified by your employer to carry out the plan administration functions that it performs for the GROUP HEALTH PLAN.
e) If applicable, to the Plan Sponsor as a summary of health information for the purpose of obtaining PREMIUM bids for providing dental BENEFITS coverage under the GROUP HEALTH PLAN or modifying, amending, or terminating the GROUP HEALTH PLAN.
f) To other companies as is necessary to process your claims. For example, claim and transactional information is transmitted to the company that processes and prints CLAIMs statements. These companies are required by agreements to use this information only for the purpose for which it was disclosed.

g) As REQUIRED BY LAW. For example, DDPAR may be required to disclose the information described above in response to a court order or subpoena or as required by a regulatory investigation.
h) To companies that perform marketing services on our behalf. DDPAR may disclose the information DDPAR collects, as described above. These companies are required by agreements to use this information only for the purpose for which it was disclosed.
i) As necessary to prevent fraud or unauthorized use.
j) As otherwise required or permitted by HIPAA or federal or state law without your authorization.

7.03 HOW INFORMATION IS PROTECTED

DDPAR maintains and implements all physical, electronic, and procedural safeguards that comply with federal regulations to guard your INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION and to prevent its use or DISCLOSURE other than as described above.

ARTICLE 8. GENERAL PROVISIONS

8.01 ENTIRE CERTIFICATE - CHANGES. The CONTRACT, including the SCHEDULE OF BENEFITS and any endorsements or amendments issued by DDPAR, make up the entire CONTRACT between the parties. The CERTIFICATE is evidence of coverage, but it is not controlling. If there is conflict between the CONTRACT and the CERTIFICATE, the CONTRACT will control. No agent has authority to change this CERTIFICATE or waive any of its provisions. No change in this CERTIFICATE will be valid unless made by written amendment signed by both an Officer of DDPAR and GROUP SPONSOR. Verbal approval(s) of coverage and/or BENEFITS shall not modify this agreement in any way and are invalid and void and of no effect.

8.02 SEVERABILITY. If any part of this CERTIFICATE or any amendment is found to be illegal, void, or not enforceable, all other portions will remain in full force and effect until cancelled as provided by the CONTRACT.

8.03 CONFORMITY WITH STATE LAWS. The laws of the State of Arkansas will govern this CERTIFICATE. Any part of this CERTIFICATE, which, on its EFFECTIVE DATE, conflicts with the laws of Arkansas is amended to conform to the minimum requirements of such laws.

8.04 LEGAL ACTIONS. No action at law or in equity will be brought before sixty (60) days after proof of loss has been filed as required by this CERTIFICATE, nor prior to the completion of all administrative remedies. Any action must be brought within five (5) years from the time proof of loss is required by this CERTIFICATE. In any case, action may only be brought after a PARTICIPANT has exercised all the review and appeal rights and completed all administrative remedies under this CERTIFICATE.

8.05 CHOICE OF JURISDICTION. All litigation related to the terms or conditions of this CERTIFICATE will be in a court of valid jurisdiction in Pulaski County, Arkansas.

8.06 DOES NOT REPLACE WORKERS' COMPENSATION. This CERTIFICATE does not affect any requirements for coverage by Worker's Compensation Insurance.

8.07 CONFLICTS. The terms of the CONTRACT, along with any amendments or endorsements entered into between GROUP SPONSOR and DDPAR, will in all cases be controlling. Should the wording of this CONTRACT, along with any amendments or endorsements entered into between GROUP SPONSOR and DDPAR conflict with the SCHEDULE OF BENEFITS, APPLICATION, or proposal, the CONTRACT, along with any amendments or endorsements entered into between GROUP SPONSOR and DDPAR will govern.

8.08 RIGHT TO RECOVERY. Whenever BENEFITS greater than the maximum amount of allowable BENEFITS are provided, DDPAR will have the right to recover any excess. DDPAR will recover the excess from any persons, insurance companies, or other organizations involved to whom the payment was made. Any PARTICIPANT covered under the CONTRACT will execute and deliver any necessary documents and do what is necessary to secure such rights to DDPAR.

8.09 SUBROGATION. DDPAR acquires the PARTICIPANT's legal rights to recovery for payment for dental services the patient required because of the action or fault of another. DDPAR has the right to recover from the PARTICIPANT any payments made by or for the other party. In such cases, DDPAR has the right to recover amounts equal to the BENEFITS paid by DDPAR. DDPAR also has the right to recover collection costs and attorney's fees in the proportion each benefits from the recovery.

DDPAR has the right to make the recovery by suit, settlement, or otherwise from the person who caused the dental problem or injury. Such recovery may be from the other person, his or her insurance company, or any other source, such as third party motorist coverage.

The PARTICIPANT must help DDPAR recover from other sources. PARTICIPANT must provide all requested information and sign necessary documents. If the PARTICIPANT fails to help DDPAR or settles any CLAIM without DDPAR's written consent, DDPAR may recover from the PARTICIPANT. DDPAR will be entitled to any recovery received by the PARTICIPANT and reasonable attorney's fees and court costs.

8.10 ENDORSEMENTS/AMENDMENTS. This CONTRACT is subject to amendments or endorsements entered into by DDPAR and GROUP SPONSOR. Nothing contained in any amendment or endorsement shall affect any of the conditions, provisions, or limitations of the CONTRACT except as expressly provided in the endorsement or amendment.. All conditions, provisions, and limitations of the CONTRACT shall apply to any endorsement or amendment entered into by the parties if they are not in conflict.

8.11 SUBCONTRACTOR(S) AND AGENT(S). DDPAR may subcontract certain functions or appoint an agent or agents to act on DDPAR'S behalf. The agent(s) may fulfill expressed, limited duties under this CERTIFICATE. Such agent(s) have no authority to change or amend this document.

8.12 DDPAR LIABILITY. DDPAR shall have no liability for any wrongful conduct as described in this paragraph. This includes but is not limited to tortuous conduct, negligence, wrongful acts or omissions, or any other act of DENTISTs, dental assistants, dental hygienists, dental EMPLOYEEs, hospitals, or hospital EMPLOYEEs providing services. DDPAR shall also have no liability for any services, equipment, or facilities.

8.13 RIGHT TO INFORMATION. In order for CLAIMs to be approved and in accordance with HIPAA, DDPAR, upon its request, shall be entitled to receive from any attending or examining DENTIST or from hospitals in which a DENTIST's care is rendered certain information and records. This data will relate to the attendance to, examination of, or TREATMENT rendered to a PARTICIPANT. DDPAR, at its own expense, shall have the right but not the duty to cause any PARTICIPANT to be examined when and as often as it reasonably requires for purposes of determining appropriate TREATMENT. The receipt of any PARTICIPANT of any service constitutes the consent of such PARTICIPANT to the release to DDPAR of all such information and records. The PARTICIPANT shall execute a medical release as requested by DDPAR.

GROUP SPONSOR agrees to provide DDPAR current, complete, and correct information in regard to all SUBSCRIBERs who are entitled to coverage. This will enable DDPAR to properly affect coverage and to administer CLAIMs and provide service for all related matters.

8.14 MISREPRESENTATIONS. In the absence of fraud, all statements made by applicants or the GROUP SPONSOR or by a PARTICIPANT shall be deemed representations and not warranties.

8.15 NOTICE TO PARTICIPANTS AND SUBSCRIBERS. Pursuant to the Gramm-Leach-Bliley Act (GLB) and Regulation 74 enacted by the Arkansas Insurance Department, DDPAR shall provide notice to its customers about its privacy policies and practices. Notice will be made upon an individual's enrollment in the Plan and annually thereafter for the duration of the term of coverage. DDPAR and GROUP SPONSOR shall provide notices about its privacy policies to SUBSCRIBERS and PARTICIPANTS as they are required in accordance with federal or state law.

8.16 FRAUD NOTICE. Any person who knowingly presents a false or fraudulent CLAIM for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

8.17 DeltaUSA. The parties acknowledge that DDPAR is subject to certain Rules and Regulations (and that same may be amended from time to time) by DeltaUSA, a national organization. The parties will act in good faith to comply with any such Rules and Regulations (and amendments, if any).

8.18 STATEMENT OF ERISA RIGHTS. As a PARTICIPANT in this dental BENEFITS plan, you are entitled to certain rights and protections under the EMPLOYEE Retirement Income Security Act (ERISA) of 1974. ERISA provides that all plan PARTICIPANTS shall be entitled to:

Receive Information About Your Plan and BENEFITS

Examine, at no charge, at the PLAN ADMINISTRATOR's office and at other specified locations, such as worksites or union halls, all documents governing the plan. This includes insurance CONTRACTs and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the US Insurance Department of Labor. This is available at the Public DISCLOSURE Room of the Employee Benefits Security Administration. .

Obtain, upon written request to the PLAN ADMINISTRATOR, copies of documents governing the operation of the plan. Documents include insurance CONTRACTs and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The PLAN ADMINISTRATOR may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The PLAN ADMINISTRATOR is REQUIRED BY LAW to furnish each PARTICIPANT with a copy of the summary annual report.

Continue GROUP HEALTH PLAN Coverage

Continue health care coverage for yourself or for your DEPENDENTs if there is a loss of coverage under the plan as a result of a QUALIFYING EVENT. You or your DEPENDENTs may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for PRE-EXISTING CONDITIONs. Your plan does not have exclusionary periods for PRE-EXISTING CONDITIONs. Because your plan is limited to dental coverage, it is exempt from the certification of credible coverage provisions of the Health Insurance Portability and Accountability Act (HIPAA) and Section 733 of ERISA.

Prudent Actions of Plan Fiduciaries

In addition to creating rights for plan PARTICIPANTs, ERISA gives duties to the people responsible for the operation of the EMPLOYEE benefit plan. The people who operate your plan are called "fiduciaries" of the plan, and they have a duty to do so prudently and in the interest of you and other PARTICIPANTs. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your CLAIM for a benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time restraints.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such case, the court may require the PLAN ADMINISTRATOR to provide the materials and pay you up to $110.00 a day until you receive the materials, unless they were not sent because of reasons beyond the control of the administrator. If you have a CLAIM for BENEFITS that is denied or ignored in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your CLAIM is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the PLAN ADMINISTRATOR. If you have any questions about this statement about your rights under ERISA, or if you need assistance in obtaining documents from the PLAN ADMINISTRATOR, you should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor. This will be listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue N.W., Washington, DC, 20210. You may also obtain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration

If we at Delta Dental of Arkansas fail to provide you with reasonable and adequate service, feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2640
(800) 852-5494

Delta Dental of Arkansas
P.O. Box 15965
Little Rock, AR 72231
(501) 835-3400
(800) 462-5410
www.deltadentalar.com

CERTIFICATE OF COVERAGE

The coverage set out in this CERTIFICATE is offered to the group at the rates stated in and upon the terms and conditions set out in the employer CONTRACT. This includes all schedules, endorsements, APPLICATION AND AGREEMENT FOR EMPLOYERS, and amendments. Delta Dental of Arkansas (DDPAR) has caused this CERTIFICATE to be duly executed as of the service date confirmed by notice.

DELTA DENTAL OF ARKANSAS

BY: 

President

"Any person who knowingly presents a false or fraudulent CLAIM for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

TABLE OF CONTENTS

Congratulations! We are pleased that you selected Delta Dental of Arkansas (DDPAR) for your dental coverage. DDPAR is a leader in dental care – both in Arkansas and in the nation.

We are giving you this booklet that will explain the coverage and services provided under the group dental BENEFITS program sponsored by your employer. Complete details of your coverage are set out in the group CONTRACT. The CONTRACT is in your Employee Benefits Department.

Under your DDPAR program, you may seek services from any DENTIST you choose. However, INDIVIDUALs may receive a **higher level of BENEFITS by seeking care from a PARTICIPATING DENTIST.**

PARTICIPATING DENTISTs will complete and submit CLAIM FORMs for you at no charge. PARTICIPATING DENTISTs agree to accept the DDPAR MAXIMUM PLAN ALLOWANCE (MPA) for covered procedures. PARTICIPATING DENTISTs will not bill you for any amount over the MAXIMUM PLAN ALLOWANCE (MPA). Since we will pay the PROVIDER directly, you don't have to pay the entire bill and wait to be paid back.

If you visit a NON-PARTICIPATING DENTIST, you may have to complete the forms yourself or pay a service charge. You may have to pay the NON-PARTICIPATING DENTIST in advance for the entire bill. If so, DDPAR will pay any BENEFITS due to you after the CLAIM is submitted. Also, NON-PARTICIPATING DENTISTs have not agreed to accept the MAXIMUM PLAN ALLOWANCE (MPA) that DDPAR will pay. As a result, you will be responsible for any difference between the DENTIST's fee and the DDPAR payment. **Also, the benefit allowance for services of a NON-PARTICIPATING DENTIST may be reduced as indicated on your SCHEDULE OF BENEFITS for eligible services after applying the applicable DEDUCTIBLEs, co-payments, and maximums. This means your out-of-pocket expense may be more if you choose a NON-PARTICIPATING DENTIST.**

How do I select a DENTIST?
The easiest and most accurate listing of PROVIDERs is on our website. Click on our PROVIDER Directory link. Once at the web page, select the "Searching for a DENTIST" icon. From the "Product Selection" menu choose the network selected by your group as noted on your SCHEDULES OF BENEFITS (Delta Dental Premier or Delta Dental PPO). By entering the information requested, we will provide you with a list of PARTICIPATING DENTISTs in your area.

This booklet contains a summary in English of your plan rights and BENEFITS as a PARTICIPANT of your group's dental plan. If you have trouble understanding any part of this booklet, contact DDPAR's Customer Service Department at (800) 462-5410. Office hours are from 7:30 a.m. to 7:00 p.m. C.S.T., Monday through Friday.

Thank you for selecting Delta Dental of Arkansas. We look forward to serving you.

DELTA DENTAL OF ARKANSAS

CERTIFICATE OF COVERAGE

This CERTIFICATE OF COVERAGE (CERTIFICATE) gives your rights and duties as a Covered Person. Please read your CERTIFICATE carefully and be familiar with its terms.

The policy may require that the SUBSCRIBER pay part or all of the required PREMIUMs through your employer. You can get information regarding the PREMIUM and any part of the PREMIUM you may pay from your employer.

This policy is issued on the basis of the employer's APPLICATION AND AGREEMENT FOR EMPLOYERS and payment of the required PREMIUM. The APPLICATION AND AGREEMENT FOR EMPLOYERS is a part of the policy. Delta Dental of Arkansas will provide coverage to covered persons subject to the terms, conditions, exclusions, and limitations of the policy.

The policy takes effect on the date specified and will be continued in force by timely payment of the PREMIUMs when due. The policy is subject to termination as provided. All coverage under the policy will be effective at 12:01 a.m. and will end at 12:00 midnight C.S.T.

This CERTIFICATE is delivered in the State of Arkansas and is governed by the laws of the State of Arkansas.

ARTICLE 1. DEFINITIONS

As used in this CERTIFICATE:

The definitions of certain capitalized words used in this CERTIFICATE are set forth in this Article 1. Unless defined within the text of this CERTIFICATE or the context clearly denotes otherwise, these capitalized words will have the meaning set forth below.

"ANNUAL MAXIMUM BENEFIT" is the sum that DDPAR will pay for BENEFITS for any BENEFIT PERIOD.

"APPLICATION" or "**APPLICATION AND AGREEMENT FOR EMPLOYERS"** is the form used for the GROUP SPONSOR to apply for coverage pursuant to the CONTRACT as provided by DDPAR.

"BENEFITS" means the sums that DDPAR will pay for limited-scope dental services under GROUP SPONSOR's CONTRACT as set out in this document, subject to the conditions, limitations, and restrictions set forth herein.

"BENEFIT PERIOD" is the twelve (12) month period during which BENEFITS are paid as set out in the SCHEDULE OF BENEFITS. This represents the accumulation period applicable to DEDUCTIBLEs, benefit maximums, and applicable time limits.

"CALENDAR YEAR" means the twelve (12) months beginning on January 1 and ending on December 31 of each year.

"CERTIFICATE OF COVERAGE (CERTIFICATE)" is a document evidencing that certain insurance coverage/protection is provided to a GROUP SPONSOR for the benefit of its subscribing ELIGIBLE RETIREEs. This insurance protection is more specifically set out pursuant to the terms and conditions set out in the CONTRACT by and between the GROUP SPONSOR and DDPAR.

"CLAIM" means a request for BENEFITS under the CONTRACT made in accordance with the CONTRACT's procedures for filing benefit CLAIMs. A CLAIM includes a request for payment for a service, supply, prescription drug, equipment or TREATMENT covered by the CONTRACT. A CLAIM must be made in accordance with the CLAIMs procedures under the CONTRACT as set forth in CLAIMs procedure section of the CONTRACT. A CLAIM does not include any BENEFITS inquiries where such inquiries do not follow the requirements established in the CLAIMs procedures.

"CLAIMS ADMINISTRATOR" is Delta Dental of Arkansas (DDPAR).

"CLAIM FORM" is the standard dental form used to file a CLAIM or request PRE-DETERMINATION of BENEFITS issued by CLAIMS ADMINISTRATOR.

"COBRA" means Title X of Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272).

"COBRA-PARTICIPANT" is a PARTICIPANT who ceases to be eligible as a SUBSCRIBER or DEPENDENT but chooses to continue coverage as allowed for the time periods provided under COBRA.

"CODE" means the Internal Revenue CODE of 1986, as amended.

"CONTRACT" is the agreement between DDPAR and GROUP SPONSOR, including the APPLICATION, all schedules, endorsements, and amendments as issued by DDPAR.

"CONTRACT TERM" is the time commencing on the EFFECTIVE DATE plus any renewals or extensions while the CONTRACT is in effect. The CONTRACT TERM will end with the termination or cancellation of the CONTRACT.

"CONTRACT YEAR" is the twelve (12) months starting on the EFFECTIVE DATE and each subsequent twelve (12) months while the CONTRACT is in effect.

"DDPAR" is Delta Dental of Arkansas, an Arkansas Not-for-Profit Corporation. As used in this CERTIFICATE, DDPAR may refer to Delta Dental of Arkansas acting on its own behalf or acting on behalf of or in conjunction with a member or members of the Delta Dental Plans Association, DeltaUSA, or their successors and/or assigns.

"DEDUCTIBLE" is the amount the PARTICIPANT must pay for services in any BENEFIT PERIOD before certain BENEFITS will be paid under the CONTRACT, subject to limitations shown on the SCHEDULE OF BENEFITS.

"DELTA DENTAL PPO PLUS PREMIER" is a preferred provider organization that can reduce the out-of-pocket expenses for the SUBSCRIBER and ELIGIBLE DEPENDENTs if they receive care from one of DDPAR's PPO DENTISTs. This program has back-up coverage through DELTA DENTAL PREMIER when treatment is received from a NON-PPO DENTIST. (Please see the front page of the GROUP CONTRACT or the SCHEDULE OF BENEFITS for the network selected for your GROUP HEALTH PLAN.)

"DENTIST" is a person licensed to practice dentistry when and where services are performed.

- **"DELTA DENTAL PPO DENTIST"** is a dentist who has signed an agreement with DDPAR to be a preferred provider. The PPO dentist accepts DDPAR's payment and patient's payment, if any, as payment in full.
- **"DELTA DENTAL PREMIER DENTIST"** is a dentist who has signed an agreement with DDPAR to participate in DELTA DENTAL PREMIER. The PARTICIPATING DENTIST accepts DDPAR's payment and the patient's payment, if any, as payment in full.
- **"NON-PARTICIPATING DENTIST"** is a DENTIST who has not signed an agreement with DDPAR. It is the SUBSCRIBER's responsibility to make full payment to the NON-PARTICIPATING DENTIST.

"DEPENDENT" is as defined in Schedule E of the CONTRACT.

"DISCLOSURE" means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

"EFFECTIVE DATE" of this CONTRACT is 12:01 a.m. on the date coverage under the CONTRACT begins, as shown on the APPLICATION.

"ELIGIBLE DEPENDENT" is a DEPENDENT who meets the eligibility requirements as set forth in Schedule E of the CONTRACT.

"ELIGIBLE EMPLOYEE" is an EMPLOYEE who meets the eligibility requirements as set forth in Schedule E of the CONTRACT.

"ELIGIBLE RETIREE" is a RETIREE who meets the eligibility requirements as set forth in Article 2.

"EMPLOYEE" is an INDIVIDUAL employed by the GROUP SPONSOR.

"ENROLLMENT FORM" is the electronic system utilized by GROUP SPONSOR, or paper form submitted to apply for coverage for an ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENTs, if applicable under the CONTRACT between the GROUP SPONSOR and DDPAR.

"FULL TIME STUDENT" is defined as an unmarried student who is DEPENDENT the RETIREE for support and maintenance and who meets the criteria of FULL TIME STUDENT status. Full time is twelve (12) hours for an undergraduate student and nine (9)

hours for a graduate school student per semester or students enrolled at a vocational school attending classes four (4) hours per day are considered full-time.

"GROUP HEALTH PLAN" is the group dental BENEFITS program to which the CONTRACT applies.

"GROUP SPONSOR" is any individual, partnership, association, corporation, or organization which agrees to sponsor a group of ELIGIBLE EMPLOYEEs or ELIGIBLE RETIREES and ELIGIBLE DEPENDENTs. It will pay or collect and remit by the due date to DDPAR the PREMIUMs payable by the members, either by payroll allotment or otherwise. It will also receive notice, CERTIFICATE, or rider from DDPAR on behalf of such members. The GROUP SPONSOR shall act only as agent of the group members. The GROUP SPONSOR shall not be the agent of DDPAR for any purpose.

"HEALTH INSURANCE ISSUER" means an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in the State of Arkansas and is subject to Arkansas law that regulates insurance.

"INDIVIDUAL" means a person who is the subject of PROTECTED HEALTH INFORMATION.

"INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION" is information that is a subset of health information, including demographic information collected from an INDIVIDUAL, and:

a) is created or received by a health care PROVIDER, health plan, group, or healthcare clearinghouse, and
b) relates to the past, present, or future physical or mental health or condition of an INDIVIDUAL, or the past, present, or future PAYMENT for the provision of health care to an INDIVIDUAL, and
c) that identifies an INDIVIDUAL, or
d) with respect to which there is a reasonable basis to believe the information can be used to identify the INDIVIDUAL.

"MAXIMUM PLAN ALLOWANCE" is the maximum payment allowed by DDPAR for the applicable covered service(s) provided by the DENTIST(s).

"NON-PARTICIPATING DENTIST" is any DENTIST other than a PARTICIPATING DENTIST.

"PARTICIPANT" is an ELIGIBLE EMPLOYEE, ELIGIBLE RETIREE or an ELIGIBLE DEPENDENT who is enrolled under the CONTRACT.

"PARTICIPATING DENTIST" or "NETWORK PROVIDER" is a licensed DENTIST who has contracted with and agreed to abide by the rules and regulations of DDPAR or any other organization that is a member of Delta Dental Plans Association, DeltaUSA, or its affiliates.

"PLAN ADMINISTRATOR" is the administrator of the CONTRACT, which is the GROUP SPONSOR.

"PRE-DETERMINATION" is an opinion from DDPAR as to payments that would be made by DDPAR as reasonably necessary for anticipated TREATMENT of a PARTICIPANT. The opinion is based upon information forwarded to DDPAR. It does not guarantee such payment in that actual payment would also depend on applicable coverage being in effect at the time any such services were rendered. The payment may also be subject to DEDUCTIBLE, co-insurance, and maximum BENEFITS allowed. Similar terms also used for PRE-DETERMINATION are pre-authorization, prior-authorization, pre-TREATMENT review, and/or, pre-certification. A PARTICIPANT, however, is not required to seek a PRE-DETERMINATION for any TREATMENT under this CERTIFICATE.

"PRE-EXISTING CONDITION" means the state or condition of the mouth that exists prior to the patient's EFFECTIVE DATE of COVERAGE under this CERTIFICATE.

"PREMIUM" is the monthly amount to be paid, as agreed, by GROUP SPONSOR to DDPAR for coverage under the CONTRACT.

"PROVIDER" means a legally licensed DENTIST or any other legally licensed dental practitioner rendering services. Services must be covered under the CONTRACT and be within the scope of the DENTIST or other legally licensed dental practitioner's license.

"QUALIFYING EVENT" means the occurrence of a specified event that would allow an ELIGIBLE EMPLOYEE and/or ELIGIBLE DEPENDENT to enroll in coverage or drop coverage after the eligibility date and at a time other than the annual enrollment period.

"RETIREE" is an INDIVIDUAL retired from the employment with the GROUP SPONSOR.

"REQUIRED BY LAW" means a mandate contained in law that compels a covered entity to make a use or DISCLOSURE of PROTECTED HEALTH INFORMATION and that is enforceable in a court of law. REQUIRED BY LAW includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal

inspector general; or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care PROVIDERs participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public BENEFITS.

"SCHEDULE OF BENEFITS" is the document that lists the BENEFITS that will be provided a PARTICIPANT. Such SCHEDULE OF BENEFITS shall be the one in effect and for which dental PREMIUMs are remitted at the time dental care is provided.

"SUBSCRIBER" is an ELIGIBLE EMPLOYEE or ELIGIBLE RETIREE who is enrolled in the CONTRACT.

"TOTALLY DISABLED" means, in the case of a DEPENDENT child, the complete inability, as a result of illness or injury, to perform the normal activities of a person of like age and sex in good health, as certified by the Social Security Administration.

"TREATMENT" means the provision, coordination, or management of health care and related services by one or more health care PROVIDERs. This includes the coordination or management of health care by a health care PROVIDER with a third party, consultation between health care PROVIDERs relating to a patient, or the referral of a patient for health care from one health care PROVIDER to another.

"TREATMENT PLAN" is a written report showing the recommended TREATMENT of any dental disease, defect, or injury for a PARTICIPANT prepared by a DENTIST as a result of any examination made by such DENTIST while coverage under the CONTRACT is in effect for the PARTICIPANT.

"URGENT CARE" involves medical care or TREATMENT that is necessary and reasonable and if not provided:

a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
b) In the opinion of a physician with knowledge of the claimant's medical condition would subject the claimant to severe pain that cannot be adequately managed without the care or TREATMENT that is the subject of the CLAIM.

"USE" means, with respect to INDIVIDUALLY IDENTIFIABLE HEALTH INFORMTION, the sharing, employment, application, utilization, examination, or analysis of information within an entity that maintains such information.

"USERRA" means the Uniform Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE 2. ELIGIBILITY AND ENROLLMENT

2.01 ELIGIBLE RETIREES. All RETIREE(s) of the GROUP SPONSOR on the EFFECTIVE DATE will be eligible to enroll for coverage under the CONTRACT.

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RETIREEs of the GROUP SPONSOR and as designated by the GROUP SPONSOR will be eligible to enroll for coverage under this CONTRACT. All RETIREEs will be eligible to enroll for coverage within 31 days of their retirement date.

2.02 INITIAL PLAN ENROLLMENT-RETIREES. RETIREE(s) and their ELIGIBLE DEPENDENT(s) must enroll for coverage within thirty one (31) days from the RETIREE's date of retirement. RETIREE(s) and ELIGIBLE DEPENDENTs who do not do so, and who do not enroll within thirty-one (31) days of a QUALIFYING EVENT or as described below, will not be able to enroll at a future date.

A QUALIFYING EVENT for enrollment occurs when an individual becomes an ELIGIBLE DEPENDENT of the RETIREE through marriage, birth, adoption, placement for adoption, or establishment of legal wardship or guardianship.

RETIREEs and ELIGIBLE DEPENDENTs must enroll for coverage within thirty one (31) days from the QUALIFYING EVENT. Notwithstanding the foregoing, if the QUALIFYING EVENT results from the birth or adoption of a child, and the child is under the age of three (3), the child may be enrolled, as applicable, at any time until the first of the calendar month following the child's third birthday.

Coverage for an adopted child shall begin on the date of the filing of a petition for adoption if the ELIGIBLE RETIREE applies for coverage within sixty (60) days after the filing of the petition for adoption. However, the coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the child.

If a DEPENDENT of a RETIREE loses coverage due to the occurrence of their birthday as specified in the APPLICATION, and said DEPENDENT enrolls in an eligible college or university on a full-time basis, that FULL-TIME STUDENT can be enrolled under a QUALIFYING EVENT.

2.03 **ANNUAL ENROLLMENT PERIOD-RETIREES.** RETIREEs and ELIGIBLE DEPENDENTs who do not enroll for coverage on a timely basis upon initial eligibility or upon a QUALIFYING EVENT will not be permitted to enroll at a future date. RETIREES who have enrolled in a timely manner may cancel their enrollment during any annual enrollment period, or at any time of the year. Once RETIREES cancel their coverage, they may not reenroll at a future date.

2.04 ELIGIBLE DEPENDENTS. ELIGIBLE DEPENDENTs include SUBSCRIBER's legally married spouse (not legally separated), same sex domestic partner as defined by the GROUP and each child who is the age specified in the APPLICATION or younger. Such DEPENDENT must be a resident of the United States. Under certain circumstances, the SUBSCRIBER may be required to provide PLAN ADMINISTRATOR or DDPAR with proof of the SUBSCRIBER/DEPENDENT relationship.

The term child means a) a natural born child, b) a stepchild, c) an adopted child or a child lawfully placed with you for adoption, d) a child for whom the ELIGIBLE RETIREE is the legal guardian, or e) a child for whom the ELIGIBLE RETIREE is legally required to provide medical coverage, or f) same-sex domestic partner's children, if those children are listed on the ELIBIGLE RETIREE's federal tax return as a DEPENDENT. An ELIGIBLE RETIREE'S grandchild is eligible only if the ELIGIBLE RETIREE's child (who is the parent of the grandchild and is an ELIGIBLE DEPENDENT) is enrolled in the plan and the grandchild lives in the same residence and is dependent on the ELIGIBLE RETIREE for support (grandchild or the parent of the grandchild must be listed on the ELIGIBLE RETIREE's federal tax return as a DEPENDENT.)

For Louisiana state residents, grandchildren up to age 26 are eligible if the ELIGIBLE RETIREE has legal custody of the grandchild and the grandchild resides with the ELIGIBLE RETIREE. The grandchild may be eligible regardless of student or marital status. Grandchildren age 26 or over who are incapable of self-support because of a disability and were covered under the Windstream plans prior to reaching the limiting age of 26 may be able to continue coverage subject to annual recertification.

No individual may be covered under this PLAN as both a RETIREE and a DEPENDENT. Also, no individual will be considered an ELIGIBLE DEPENDENT of more than one RETIREE.

A RETIREE'S DEPENDENT child who is a FULL TIME STUDENT will continue to be an ELIGIBLE DEPENDENT until the day such DEPENDENT child attains the limiting age as defined by the APPLICATION. School vacation periods during any CALENDAR YEAR which interrupt but do not terminate what otherwise would have been a continuous course of study in that CALENDAR YEAR shall be considered part of school attendance on a FULL TIME STUDENT basis.

If an unmarried, DEPENDENT child of a RETIREE, upon reaching age nineteen (19), is TOTALLY DISABLED and resides with the SUBSCRIBER, such DEPENDENT child will continue to be an ELIGIBLE DEPENDENT under the CONTRACT until such time as the DEPENDENT child is no longer TOTALLY DISABLED or coverage under the CONTRACT terminates for any reason.

The RETIREE will be required to provide DDPAR or GROUP SPONSOR with written evidence of a DEPENDENT child's FULL TIME STUDENT status, if applicable, or disability status.

2.05 EFFECTIVE DATE OF COVERAGE. Coverage for an ELIGIBLE RETIREE or ELIGIBLE DEPENDENT who timely enrolls will be effective on whichever of the following occurs first:

ELIGIBLE RETIREE:

a) The 1st of the month following the date of retirement for RETIREEs and ELIGIBLE DEPENDENTS, provided RETIREE and ELIGIBLE DEPENDENTS enroll within thirty-one (31) days of the retirement date (date of employment termination);
b) The date of the status change following the date of the QUALIFYING EVENT, provided ELIGIBLE RETIREE enrolls within thirty-one (31) days from the ENROLLMENT QUALIFYING EVENT;

2.06 A RETIREE loses coverage when RETIREE BENEFITS are terminated by the GROUP SPONSOR, when applicable PREMIUM(s) are not paid/received, when RETIREE loses eligibility, or at the end of the CONTRACT. DEPENDENT(s)

will lose coverage along with the RETIREE or earlier if DEPENDENT loses his or her DEPENDENT status. RETIREE(s) will lose coverage on the last day of the month during which last covered as a RETIREE.

2.06 Possession of an identification card does not guarantee a PARTICIPANT is eligible for BENEFITS. Eligibility is based on information reported to DDPAR by the group. Eligibility may be confirmed by calling DDPAR's Customer Service Representatives, but the card **is not a guarantee of payment.**

2.07 DDPAR will not continue to pay BENEFITS for any PARTICIPANT(s) when they lose eligibility upon notification from the GROUP SPONSOR. As provided by COBRA, USERRA, or any applicable state continuation of coverage provision, if applicable, coverage may continue for up to eighteen (18) months where the RETIREE's coverage ends as a result of a termination of RETIREE benefits in accordance with and pursuant to such provisions.

Under COBRA, or an applicable state continuation of coverage provision, DEPENDENTs may continue coverage under this CONTRACT for up to thirty-six (36) months.
In any case, coverage shall end if the PARTICIPANT fails to pay the required PREMIUM to the GROUP SPONSOR, becomes eligible for Medicare, obtains other group coverage, or the GROUP SPONSOR cancels group dental coverage.

If applicable, PARTICIPANTs must choose whether or not to continue their coverage. PARTICIPANTs have sixty (60) days to make such an election. The sixty (60) day period shall start at the earlier of the date the PARTICIPANT's coverage would otherwise end or the date the PARTICIPANT receives notice of his/her rights. **GROUP SPONSOR should terminate PARTICIPANT's coverage until election is made and PAYMENT is received.** Coverage will be reinstated with no break.

RETIREE is responsible for notifying the GROUP SPONSOR immediately of any change(s) in eligibility. RETIREE should tell GROUP SPONSOR of changes in DEPENDENT status, divorce, or eligibility for Medicare.

It shall be PLAN ADMINISTRATOR's sole responsibility to ensure that all COBRA, or any other applicable state continuation of coverage provisions are complied with.

2.08 **TAKE OVER PROVISIONS.** Within sixty (60) days from the date of the end of a prior plan, DDPAR will cover all ELIGIBLE RETIREEs and DEPENDENTs:

a) If each RETIREE or DEPENDENT was validly covered under the previous plan at the date of the end of the plan.
b) If each RETIREE or DEPENDENT is a member of the class of INDIVIDUALs eligible for coverage under the prior carrier's plan, regardless of any of the plan's limitations or exclusions related to "actively at work" or hospital confinement.
c) Only if the group accident and health BENEFITS were provided to a group consisting of more than fifteen (15) members.

The succeeding carrier should be entitled to deduct from its BENEFITS any BENEFITS payable by the prior carrier pursuant to an extension of BENEFITS provision.

No provision in a succeeding carrier's plan of replacement coverage which would operate to reduce or exclude BENEFITS on the basis the condition giving rise to BENEFITS pre-existed the EFFECTIVE DATE of the succeeding carrier's plan shall be applied with respect to those ELIGIBLE RETIREEs and DEPENDENTs validly insured under the previous carrier's policy on the date of discontinuance, and only if BENEFITS for the condition would have been payable under the previous carrier's plan.

This will apply upon the issuance of an insurance policy or health care plan:

a) To a group whose BENEFITS had previously been self-insured.
b) To a self-insurer providing coverage to a group which had been previously covered by an insurer.
c) To a group which had been previously covered by an insurer.

ARTICLE 3. EXCLUSIONS FOR ALL BENEFITS

3.01 DDPAR will only pay the BENEFITS stated for each type of dental service set out in the SCHEDULE OF BENEFITS. **Not all dental services are BENEFITS under the CONTRACT**. BENEFITS will only be provided for PARTICIPANTs who are enrolled on the date of TREATMENT. BENEFITS will be determined based on the date services were rendered. Services must be provided by a DENTIST or properly licensed EMPLOYEE of the DENTIST. Services must be necessary and customary. Services must be provided following generally accepted dental practice standards as determined by the dental profession to be a paid benefit. DDPAR will pay allowable BENEFITS based upon the percentages and subject to the ANNUAL MAXIMUM BENEFIT as stated in the SCHEDULE OF BENEFITS. Such percentages will be applied to the

lesser of the MAXIMUM PLAN ALLOWANCE (MPA) or the fees the DENTIST charges for the service. **The maximum payment for NON-PARTICIPATING DENTISTs may be less than to a PARTICIPATING DENTIST, please refer to your SCHEDULE OF BENEFITS.** Payments for covered services by NON-PARTICIPATING DENTISTs will be sent to the patient(s). NON-PARTICIPATING DENTISTs may balance-bill patients for the difference of their charges and DDPAR's payment. PARTICIPATING DENTISTs shall not balance-bill patients for charges in excess of the MPA for covered BENEFITS under the CONTRACT.

3.02 OPTIONAL SERVICES

a) Services that cost more than the TREATMENT usually provided under accepted dental practice standards are called Optional Services. Optional Services also include the use of specialized instead of standard procedures. BENEFITS for Optional Services will be based on the cost of the standard service. The PARTICIPANT will be responsible for the remainder of the DENTIST's fee.
b) Payment made by DDPAR for any surgical service will include charges for routine, post-operative evaluations or visits.
c) If a PARTICIPANT transfers from one DENTIST to another during the course of TREATMENT, BENEFITS will be limited to the amount that would have been paid if one DENTIST rendered the service.

3.03 EXCLUSIONS

DDPAR does not pay BENEFITS for:

a) BENEFITS or services for injuries or conditions covered under Worker's Compensation or Employer's Liability laws. BENEFITS or services available from any federal or state government agency; municipality, county, other political subdivision; or community agency; or from any foundation or similar entity.
b) Charges for services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
c) Charges for services or supplies for which no charge is made that the patient is legally obligated to pay. Charges for which no charge would be made in the absence of dental coverage.
d) Charges for TREATMENT by other than a DENTIST except that a licensed hygienist may perform services in accordance with applicable law. Services must be under the supervision and guidance of the DENTIST in accordance with generally accepted dental standards.
e) Charges for the completion of forms and/or submission of supportive documentation required by DDPAR for a benefit determination. A charge for these services is not to be made to a DDPAR-covered patient by a PARTICIPATING DENTIST.
f) BENEFITS to correct congenital or developmental malformations.
g) Services for the purpose of improving appearance when form and function are satisfactory, and there is insufficient pathological condition evident to warrant the TREATMENT (cosmetic dentistry).
h) BENEFITS for services or appliances started prior to the date the patient became eligible under this plan, including, but not limited to, restorations, prosthodontics, and orthodontics.
i) Services with respect to diagnosis and TREATMENT of disturbances of the temporomandibular joint (TMJ), unless optional coverage is purchased.
j) Services for increasing the vertical dimension or for restoring tooth structure lost by attrition, for rebuilding or maintaining occlusal services, or for stabilizing the teeth.
k) Experimental and/or investigational services, supplies, care and TREATMENT which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards or a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered. The CLAIMS ADMINISTRATOR must make an independent evaluation of the experimental or non-experimental standings of specific technologies. The CLAIMS ADMINISTRATOR's decision will be final and binding on the CONTRACT. Drugs are considered experimental if they are not commercially available for purchase and/or are not approved by the Food and Drug Administration for general use.
l) Charges for replacement of lost, missing, or stolen appliances/devices.
m) Charges for services when a CLAIM is received for payment more than twelve (12) months after services are rendered.
n) Charges for complete occlusal adjustments, occlusal guards, occlusion analysis, enamel microabrasion, odontoplasty, bleaching, and athletic mouthguards, unless noted specifically in the SCHEDULE OF BENEFITS
o) Specialized techniques that entail procedure and process over and above that which is normally adequate. Any additional fee is the patient's responsibility.
p) Behavior management.
q) Those services and BENEFITS excluded by the rules and regulations of DDPAR, including DDPAR's processing policies.
r) Removable appliances for control of harmful habits, including but not limited to tongue thrust appliances.
s) t) Procedures that do not comply with DDPAR's guidelines.

u) Charges for precision attachments, provisional splinting, desensitizing medicines, home care medicines, premedications, stress breakers, coping, office visits during or after regularly scheduled hours, case presentations, and hospital-related services.
v) All other BENEFITS and services not specifically covered in the CONTRACT and/or SCHEDULE OF BENEFITS.

ARTICLE 4. DEDUCTIBLE, MAXIMUM, AND COORDINATION OF BENEFITS

4.01 DDPAR will not pay BENEFITS until the annual DEDUCTIBLE amount has been satisfied, unless the covered procedure is not subject to the DEDUCTIBLE. The DEDUCTIBLE will apply as listed on the SCHEDULE OF BENEFITS.

4.02 The DEDUCTIBLE applies to the BENEFITS as shown on the SCHEDULE OF BENEFITS. Only fees a PARTICIPANT pays for services covered under the benefit schedules in this CERTIFICATE will count toward satisfying the DEDUCTIBLE.

4.03 Unless otherwise listed on the SCHEDULE OF BENEFITS, the DEDUCTIBLE and maximums apply to each BENEFIT PERIOD.

4.04 COORDINATION OF BENEFITS
If a PARTICIPANT is entitled to coverage under more than one insurance policy or benefit program, the BENEFITS of this CERTIFICATE will be subject to the following conditions:

a) If the other program is not primarily a dental program, this program is primary.
b) If the other program is for dental coverage, the following rules apply:
    1) The program covering the patient as a RETIREEis primary over a program covering the patient as a DEPENDENT.
    2) Where the patient is a DEPENDENT child, primary dental coverage will be determined as follows:
        i) The coverage of the parent whose date of birth occurs earlier in the CALENDAR YEAR will be primary.
        ii) Except for a DEPENDENT child of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent's spouse (i.e., stepparent) will be primary, unless there is a court decree stating that one parent has financial responsibility for a child's health care expenses. If so, any DEPENDENT coverage of that parent will be primary to any other DEPENDENT coverage.
c) When primary coverage cannot be determined according to a) and b), the program that has covered the patient for the longer period will be primary.
d) Coordination of BENEFITS within the same group will not be allowed.

If this coverage is primary, BENEFITS will be provided without regard to any other coverage. If this coverage is not primary, BENEFITS are limited to services which are BENEFITS of this CONTRACT that are not fully paid by any other coverage. However, BENFITS can not exceed the amount of actual charges for any service(s).

ARTICLE 5. CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

5.01 **CHOICE OF DENTIST**. DDPAR does not furnish covered services directly. DDPAR pays for licensed DENTISTs to provide these services. A PARTICIPANT may choose any DENTIST. PARTICIPANTs should determine the qualifications of the DENTIST they select. Participation in DDPAR is open to all DENTISTs who meet DDPAR's standards and who are licensed in Arkansas unless they have previously had their participation in DDPAR terminated. DDPAR only controls credentialing in Arkansas. However, there is currently in effect a policy by Delta Dental Plans Association (National), which is applicable to DeltaUSA groups. This policy requires all Delta Plans to have credentialing. Other state's credentialing policies are available upon request. Whether a DENTIST is a PARTICIPATING or NON-PARTICIPATING DENTIST should not be viewed as a statement about that DENTIST's abilities.

DDPAR shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, DDPAR cannot ensure your DENTIST's use of precautions against the spread of such diseases. Also, DDPAR cannot compel your DENTIST to be tested for HIV or to disclose test results to DDPAR or to a PARTICIPANT. If there are questions about your DENTIST's health status or use of recommended clinical precautions, PARTICIPANT should discuss them with the DENTIST.

5.02 **CLINICAL EXAMINATION**. Before approving a CLAIM, DDPAR may obtain from any DENTIST or hospital such information and records DDPAR may require to administer the CLAIM. DDPAR may require that a PARTICIPANT be examined by a dental consultant, retained by DDPAR, in or near his/her place of residence.

5.03 **PRE-DETERMINATION**. A DENTIST may file a CLAIM FORM showing the services he or she recommends. DDPAR will then pre-determine the BENEFITS payable under this CONTRACT. PAYMENT will only be made for pre-determined services if the PARTICIPANT receives TREATMENT for which BENEFITS are payable, remains eligible, and has not

exceeded his or her ANNUAL MAXIMUM BENEFITS. A CLAIM FORM requesting a PRE-DETERMINATION may be submitted electronically.

5.04 **TREATMENT OF BENEFITS ON LACK OF ELIGIBILITY**. DDPAR will not pay BENEFITS for any services received by a patient who is not eligible at the time of TREATMENT. GROUP SPONSOR will repay DDPAR, limited to the monthly PREMIUM, for any payments due to errors or delays in reporting by the GROUP SPONSOR.

5.05 **TO WHOM BENEFITS ARE PAID**. BENEFITS provided under this CONTRACT will be paid as follows:

a) For services provided by a PARTICIPATING DENTIST, payment will be made to the PARTICIPATING DENTIST.
b) For services provided by a NON-PARTICIPATING DENTIST, payment will be made to SUBSCRIBER. The SUBSCRIBER is responsible for all payments to a NON-PARTICIPATING DENTIST.

ARTICLE 6. CLAIMS PROCEDURES

6.01 **CLAIMS**. CLAIMs must be filed by PARTICIPANT or PARTICIPANT's authorized representative with DDPAR within twelve (12) months after completion of TREATMENT for which BENEFITS are payable. Any CLAIM filed after this period will be denied. The CLAIMS ADMINISTRATOR has complete discretion to interpret the terms of the BENEFITS under the CONTRACT and such interpretation shall be final and conclusive.

6.02 **FILING CLAIMS/PARTICIPATING DENTISTS.** PARTICIPATING DENTISTS will complete and submit CLAIM FORMs for PARTICIPANTS at no charge. PARTICIPATING DENTISTS may ask PARTICIPANTs to fill out the patient section of the CLAIM FORM, which includes the SUBSCRIBER's name, social security number (SSN), and address; the PARTICIPANT's name, date of birth, and relationship to SUBSCRIBER; and coordination of BENEFITS information, if applicable.

6.03 **FILING CLAIMS/NON-PARTICIPATING DENTISTS.** If the PARTICIPANT visits a NON-PARTICIPATING DENTIST, PARTICIPANT may be required to complete the CLAIM FORM or pay a service charge. The patient section should be completed, which includes the SUBSCRIBER's name, SSN, and address; the PARTICIPANT's name, date of birth, and relationship to SUBSCRIBER, and coordination of BENEFITS information, if applicable.

PARTICIPANT will also be responsible for ensuring the NON-PARTICIPATING DENTIST completes the DENTIST and the Diagnostic (TREATMENT) Sections of the CLAIM FORM. The DENTIST Section includes the DENTIST's name, address, SSN or TIN number, license number, and phone number. The DENTIST must also indicate whether x-rays are attached and answer questions regarding TREATMENT that is the result of an accident. The DENTIST must also indicate if dentures, bridges, and crowns are replacements, and if so, the date of prior placement and reason for replacement must be noted.

The Diagnostic Section (TREATMENT) includes services performed (name description and ADA procedure code), including date of service, fee for service, and if applicable, tooth number or letter and tooth surface. For any unusual services, the Remarks Section of the CLAIM FORM must give a brief description. The CLAIM FORM needs to be signed by the DENTIST who performed the services and by the SUBSCRIBER/PARTICIPANT.

6.04 **PROCESSING THE CLAIM.** If PARTICIPANT visits a PARTICIPATING DENTIST, upon receipt of the CLAIM, it will be processed according to the GROUP SPONSOR's CONTRACT BENEFITS. For PARTICIPANTS who visit a PARTICIPATING DENTIST, notification of the benefit determination will be sent to the SUBSCRIBER in the form of an Explanation of BENEFITS, which details by service rendered what the CONTRACT allowed and the PARTICIPANT's obligation, if any.

If PARTICIPANT visits a NON-PARTICIPATING DENTIST, the SUBSCRIBER will receive a CLAIM Payment Statement, which will detail by service rendered what the CONTRACT allowed and the PARTICIPANT's obligation, if any. The CLAIM Payment Statement will also include a benefit check made payable to the SUBSCRIBER.

6.05 **INITIAL CLAIM DETERMINATION.** If the CLAIMS ADMINISTRATOR denies all or a portion of the CLAIM, PARTICIPANT will receive an Explanation of BENEFITS (for PARTICIPANTs visiting a PARTICIPATING DENTIST) or a CLAIM Payment Statement (for PARTICIPANTs visiting a NON-PARTICIPATING DENTIST) indicating the reason for the denial. The denial explanation will be printed at the bottom of the page.

The SUBSCRIBER will be notified within thirty (30) days of the receipt of the CLAIM by CLAIMS ADMINISTRATOR of the benefit determination.

In the case of an URGENT CARE CLAIM, the SUBSCRIBER will be notified within seventy-two (72) hours from the time the CLAIM is received by the CLAIM ADMINISTRATOR of the benefit determination.

6.06 APPEAL OF DENIED CLAIM. If the CLAIMS ADMINISTRATOR has denied a CLAIM, claimant may appeal the denial. Both the claimant and CLAIMS ADMINISTRATOR must take the following steps to complete an appeal (decision review):

a) Procedures the PARTICIPANT or PARTICIPANT's attending DENTIST Must Follow:
   1) Write to the CLAIMS ADMINISTRATOR at the following address: Customer Service Support, [Post Office Box 15965, North Little Rock, Arkansas, 72231] within one-hundred-eighty days (180) of the date on the notice of PARTICIPANT's CLAIM denial.
   2) State why the CLAIM should not have been denied.
   3) Include the denial notice and any other documents, data information, or comments that claimant believe may have an influence on the appeal of the CLAIM.
   4) If requested, claimant will receive, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied CLAIM.
   5) For an expedited review of an URGENT CARE CLAIM, the request may be submitted orally (by telephone) or in writing (by facsimile or another similarly expeditious method).

b) Procedures CLAIMS ADMINISTRATOR must follow for a full and fair appeal:
   1) Identify the medical or vocational experts whose advice was obtained and utilized on behalf of CLAIMS ADMINISTRATOR in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.
   2) Not consider the initial denial in the review.
   3) Conduct a review that includes one or more of the members of the CLAIMS ADMINISTRATOR's Appeals Committee (to be determined at the sole discretion of CLAIMS ADMINISTRATOR), but in no event will the individual who made the initial CLAIM denial, nor the subordinate of that individual be part of the review.
   4) Consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted initially, nor who is the subordinate of such individual if your denial is based in whole or in part on a medical judgment, including determinations with regard to whether a particular TREATMENT, drug, or other item is experimental, investigational, or not medically necessary or appropriate.

c) Procedures CLAIMS ADMINISTRATOR must follow to notify claimant of its decision (if adverse):
   1) Provide claimant with a notice that includes the following information, to wit:
      i) The specific reason(s) for the adverse determination.
      ii) Reference to the specific CONTRACT provision(s) on which the adverse determination is based.
      iii) A statement that claimant is entitled to receive, free of charge, access to and copies of all information relevant to the CLAIM.
      iv) A statement describing any voluntary appeal procedures, if any, and a statement of claimant's right to bring an action under section 502 (a) of the EMPLOYEE Retirement Income Security Act.
      v) A statement that any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination will be provided free of charge upon request.
      vi) If adverse determination is based on a medical necessity or experimental TREATMENT, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.
      vii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."
   2) Provide claimant with the aforementioned notice within seventy-two (72) hours if the CLAIM is an URGENT CARE CLAIM.
   3) Provide claimant with the aforementioned notice within sixty (60) days if the CLAIM is a post-service CLAIM.

ARTICLE 7. DELTA DENTAL OF ARKANSAS PRIVACY POLICY STATEMENT FOR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Protecting your privacy is a priority of DDPAR. The purpose of this statement is to help you understand how DDPAR uses and protects your INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

7.01 INFORMATION DDPAR RECEIVES

DDPAR receives INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION about you from the following sources:

a) Information we receive from you on applications and other forms or from your group dental plan or employer and from our agents, PROVIDERs, and PLAN ADMINISTRATORs;
b) Information you provide to DDPAR in order to receive our services;
b) Information about your transactions with us, our affiliates, or others; and,
c) Information we receive from a DENTIST who provides dental services to you.

7.02 HOW INFORMATION IS USED AND DISCLOSED

DDPAR does not sell the INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION of its customers or former customers to any unaffiliated third parties. Such information is used for underwriting and processing your claim. This information is only provided to third parties under certain circumstances. The INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION DDPAR collects, as described above, may be disclosed as follows:

a) For TREATMENT, payment, and HEALTH CARE OPERATIONS as defined under HIPAA with respect to DDPAR's administration of your dental BENEFITS program.
b) For the proper management and administration of DDPAR.
c) To provide data aggregation services to your GROUP HEALTH PLAN.
d) If applicable, to your employer's EMPLOYEEs, classes of EMPLOYEEs, or other persons identified by your employer to carry out the plan administration functions that it performs for the GROUP HEALTH PLAN.
e) If applicable, to the Plan Sponsor as a summary of health information for the purpose of obtaining PREMIUM bids for providing dental BENEFITS coverage under the GROUP HEALTH PLAN or modifying, amending, or terminating the GROUP HEALTH PLAN.
f) To other companies as is necessary to process your claims. For example, claim and transactional information is transmitted to the company that processes and prints CLAIMs statements. These companies are required by agreements to use this information only for the purpose for which it was disclosed.
g) As REQUIRED BY LAW. For example, DDPAR may be required to disclose the information described above in response to a court order or subpoena or as required by a regulatory investigation.
h) To companies that perform marketing services on our behalf. DDPAR may disclose the information DDPAR collects, as described above. These companies are required by agreements to use this information only for the purpose for which it was disclosed.
i) As necessary to prevent fraud or unauthorized use.
j) As otherwise required or permitted by HIPAA or federal or state law without your authorization.

7.03 HOW INFORMATION IS PROTECTED

DDPAR maintains and implements all physical, electronic, and procedural safeguards that comply with federal regulations to guard your INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION and to prevent its use or DISCLOSURE other than as described above.

ARTICLE 8. GENERAL PROVISIONS

8.01 ENTIRE CERTIFICATE - CHANGES. The CONTRACT, including the SCHEDULE OF BENEFITS and any endorsements or amendments issued by DDPAR, make up the entire CONTRACT between the parties. The CERTIFICATE is evidence of coverage, but it is not controlling. If there is conflict between the CONTRACT and the CERTIFICATE, the CONTRACT will control. No agent has authority to change this CERTIFICATE or waive any of its provisions. No change in this CERTIFICATE will be valid unless made by written amendment signed by both an Officer of DDPAR and GROUP SPONSOR. Verbal approval(s) of coverage and/or BENEFITS shall not modify this agreement in any way and are invalid and void and of no effect.

8.02 SEVERABILITY. If any part of this CERTIFICATE or any amendment is found to be illegal, void, or not enforceable, all other portions will remain in full force and effect until cancelled as provided by the CONTRACT.

8.03 CONFORMITY WITH STATE LAWS. The laws of the State of Arkansas will govern this CERTIFICATE. Any part of this CERTIFICATE, which, on its EFFECTIVE DATE, conflicts with the laws of Arkansas is amended to conform to the minimum requirements of such laws.

8.04 LEGAL ACTIONS. No action at law or in equity will be brought before sixty (60) days after proof of loss has been filed as required by this CERTIFICATE, nor prior to the completion of all administrative remedies. Any action must be brought within five (5) years from the time proof of loss is required by this CERTIFICATE. In any case, action may only be brought after a PARTICIPANT has exercised all the review and appeal rights and completed all administrative remedies under this CERTIFICATE.

8.05 **CHOICE OF JURISDICTION**. All litigation related to the terms or conditions of this CERTIFICATE will be in a court of valid jurisdiction in Pulaski County, Arkansas.

8.06 **DOES NOT REPLACE WORKERS' COMPENSATION**. This CERTIFICATE does not affect any requirements for coverage by Worker's Compensation Insurance.

8.07 **CONFLICTS**. The terms of the CONTRACT, along with any amendments or endorsements entered into between GROUP SPONSOR and DDPAR, will in all cases be controlling. Should the wording of this CONTRACT, along with any amendments or endorsements entered into between GROUP SPONSOR and DDPAR conflict with the SCHEDULE OF BENEFITS, APPLICATION, or proposal, the CONTRACT, along with any amendments or endorsements entered into between GROUP SPONSOR and DDPAR will govern.

8.08 **RIGHT TO RECOVERY**. Whenever BENEFITS greater than the maximum amount of allowable BENEFITS are provided, DDPAR will have the right to recover any excess. DDPAR will recover the excess from any persons, insurance companies, or other organizations involved to whom the payment was made. Any PARTICIPANT covered under the CONTRACT will execute and deliver any necessary documents and do what is necessary to secure such rights to DDPAR.

8.09 **SUBROGATION**. DDPAR acquires the PARTICIPANT's legal rights to recovery for payment for dental services the patient required because of the action or fault of another. DDPAR has the right to recover from the PARTICIPANT any payments made by or for the other party. In such cases, DDPAR has the right to recover amounts equal to the BENEFITS paid by DDPAR. DDPAR also has the right to recover collection costs and attorney's fees in the proportion each benefits from the recovery.

DDPAR has the right to make the recovery by suit, settlement, or otherwise from the person who caused the dental problem or injury. Such recovery may be from the other person, his or her insurance company, or any other source, such as third party motorist coverage.

The PARTICIPANT must help DDPAR recover from other sources. PARTICIPANT must provide all requested information and sign necessary documents. If the PARTICIPANT fails to help DDPAR or settles any CLAIM without DDPAR's written consent, DDPAR may recover from the PARTICIPANT. DDPAR will be entitled to any recovery received by the PARTICIPANT and reasonable attorney's fees and court costs.

8.10 **ENDORSEMENTS/AMENDMENTS**. This CONTRACT is subject to amendments or endorsements entered into by DDPAR and GROUP SPONSOR. Nothing contained in any amendment or endorsement shall affect any of the conditions, provisions, or limitations of the CONTRACT except as expressly provided in the endorsement or amendment.. All conditions, provisions, and limitations of the CONTRACT shall apply to any endorsement or amendment entered into by the parties if they are not in conflict.

8.11 **SUBCONTRACTOR(S) AND AGENT(S)**. DDPAR may subcontract certain functions or appoint an agent or agents to act on DDPAR'S behalf. The agent(s) may fulfill expressed, limited duties under this CERTIFICATE. Such agent(s) have no authority to change or amend this document.

8.12 **DDPAR LIABILITY.** DDPAR shall have no liability for any wrongful conduct as described in this paragraph. This includes but is not limited to tortuous conduct, negligence, wrongful acts or omissions, or any other act of DENTISTs, dental assistants, dental hygienists, dental EMPLOYEEs, hospitals, or hospital EMPLOYEEs providing services. DDPAR shall also have no liability for any services, equipment, or facilities.

8.13 **RIGHT TO INFORMATION**. In order for CLAIMs to be approved and in accordance with HIPAA, DDPAR, upon its request, shall be entitled to receive from any attending or examining DENTIST or from hospitals in which a DENTIST's care is rendered certain information and records. This data will relate to the attendance to, examination of, or TREATMENT rendered to a PARTICIPANT. DDPAR, at its own expense, shall have the right but not the duty to cause any PARTICIPANT to be examined when and as often as it reasonably requires for purposes of determining appropriate TREATMENT. The receipt of any PARTICIPANT of any service constitutes the consent of such PARTICIPANT to the release to DDPAR of all such information and records. The PARTICIPANT shall execute a medical release as requested by DDPAR.

GROUP SPONSOR agrees to provide DDPAR current, complete, and correct information in regard to all SUBSCRIBERs who are entitled to coverage. This will enable DDPAR to properly affect coverage and to administer CLAIMs and provide service for all related matters.

8.14 **MISREPRESENTATIONS**. In the absence of fraud, all statements made by applicants or the GROUP SPONSOR or by a PARTICIPANT shall be deemed representations and not warranties.

8.15 **NOTICE TO PARTICIPANTS AND SUBSCRIBERS.** Pursuant to the Gramm-Leach-Bliley Act (GLB) and Regulation 74 enacted by the Arkansas Insurance Department, DDPAR shall provide notice to its customers about its privacy policies and practices. Notice will be made upon an individual's enrollment in the Plan and annually thereafter for the duration of the term of coverage. DDPAR and GROUP SPONSOR shall provide notices about its privacy policies to SUBSCRIBERS and PARTICIPANTS as they are required in accordance with federal or state law.

8.16 **FRAUD NOTICE.** Any person who knowingly presents a false or fraudulent CLAIM for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

8.17 **DeltaUSA.** The parties acknowledge that DDPAR is subject to certain Rules and Regulations (and that same may be amended from time to time) by DeltaUSA, a national organization. The parties will act in good faith to comply with any such Rules and Regulations (and amendments, if any).

8.18 **STATEMENT OF ERISA RIGHTS.** As a PARTICIPANT in this dental BENEFITS plan, you are entitled to certain rights and protections under the EMPLOYEE Retirement Income Security Act (ERISA) of 1974. ERISA provides that all plan PARTICIPANTS shall be entitled to:

Receive Information About Your Plan and BENEFITS

Examine, at no charge, at the PLAN ADMINISTRATOR's office and at other specified locations, such as worksites or union halls, all documents governing the plan. This includes insurance CONTRACTs and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the US Insurance Department of Labor. This is available at the Public DISCLOSURE Room Employee Benefits Security Administration.

Obtain, upon written request to the PLAN ADMINISTRATOR, copies of documents governing the operation of the plan. Documents include insurance CONTRACTs and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The PLAN ADMINISTRATOR may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The PLAN ADMINISTRATOR is REQUIRED BY LAW to furnish each PARTICIPANT with a copy of the summary annual report.

Continue GROUP HEALTH PLAN Coverage

Continue health care coverage for yourself or for your DEPENDENTs if there is a loss of coverage under the plan as a result of a QUALIFYING EVENT. You or your DEPENDENTs may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for PRE-EXISTING CONDITIONs. Your plan does not have exclusionary periods for PRE-EXISTING CONDITIONs. Because your plan is limited to dental coverage, it is exempt from the certification of credible coverage provisions of the Health Insurance Portability and Accountability Act (HIPAA) and Section 733 of ERISA.

Prudent Actions of Plan Fiduciaries

In addition to creating rights for plan PARTICIPANTs, ERISA gives duties to the people responsible for the operation of the RETIREE benefit plan. The people who operate your plan are called "fiduciaries" of the plan, and they have a duty to do so prudently and in the interest of you and other PARTICIPANTs. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your CLAIM for a benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time restraints.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such case, the court may require the PLAN ADMINISTRATOR to provide the materials and pay you up to $100.00 a day until you receive the materials, unless they were not sent because of reasons beyond the control of the administrator. If you have a CLAIM for BENEFITS that is denied or ignored in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your CLAIM is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the PLAN ADMINISTRATOR. If you have any questions about this statement about your rights under ERISA, or if you need assistance in obtaining documents from the PLAN ADMINISTRATOR, you should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor. This will be listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue N.W., Washington, DC, 20210. You may also obtain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

If we at Delta Dental of Arkansas fail to provide you with reasonable and adequate service, feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
(501) 371-2640
(800) 852-5494

SERFF Tracking #:	*DDAR-128660188*	***State Tracking #:***	***Company Tracking #:*** *WS CERTS 12A*

State:	*Arkansas*	***Filing Company:***	*Delta Dental of Arkansas*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*WS dental certs*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved-Closed	09/10/2012
Comments:	Please see attached.		
Attachment(s):			
Compliance Certification 12A.pdf			

		Item Status:	**Status Date:**
Bypassed - Item:	Application	Approved-Closed	09/10/2012
Bypass Reason:	n/a		
Comments:			

COMPLIANCE CERTIFICATION

I, the undersigned, do hereby certify and attest that to the best of my knowledge and belief:

1. The Flesch reading score of Form DDPAR-WS RETIREE CERT-12A is 36.8, and the Flesch reading score of Form DDPAR-WS_ 9618_9619_9620_ACTIVE CERT-12A is 34.5, both of which are below that required by Arkansas law; and

2. The nature of dental insurance requires the use of dental terminology such as “temperomandibular”, which will inflate the Flesch reading score; and

3. Form DDPAR-WS RETIREE CERT-12A should be approved with a Flesch reading score of 36.8, and Form DDPAR-WS_ 9618_9619_9620_ACTIVE CERT-12A should be approved with a Flesch reading score of 34.5.

Signed this 27th day of August, 2012.

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Sara Farris, Director of Compliance